

March 1954

Medical Economics



Who Will Run the Blood Banks?

Also in this issue:

This Study Plan Meets G.P.s' Needs

If Fire Strikes, Can You Collect?

Medical Care Costs in the U.S.

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provides this
four way relief
of peptic ulcer



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2	Antipeptic		
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Prescribe two to four teaspoonfuls Kolantyl Gel or two tablets (chewed for more rapid action) every 3 hours, or as needed for relief.

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1. HUFFORD, A. R., MICH. STATE MED. SOC. 48: 1308, 1950. 2. MC HARDY, G. AND BROWN, B. A. SOU. MED. J. 48: 1139, 1952.

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March 1954

Medical Economics

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Panorama

Sees doctor draft ending

soon • Medical school fund growing • Kaiser proposes new
closed-panel plan • Chiropractors twist legislature's arm •
Hospital costs continue to climb • Legion charge answered

Schools Pool Resources

Given a green light by Congress, eight Western states are now combining their teaching resources in order to train more doctors. The plan, which is being handled by the Western Interstate Commission for Higher Education, permits both students and state funds to cross state lines so that the whole area can make the most out of existing or future facilities. Among the steps already taken:

1. The commission has collected more than \$300,000 from Arizona, Colorado, Idaho, Montana, New Mexico, Oregon, Utah, and Wyoming to cover the various costs of training.

2. And it has assigned sixty-two students from states lacking the necessary facilities to schools of medicine, dentistry, and veterinary medicine in other states.

Eventually, the commission believes, it may be necessary to build new medical schools. But its first objective, says Executive Director

William C. Jones, is "to make sure that every available school in the area is filled to optimum size with students having the maximum chance of professional success."

Old House, Low Price

If you're thinking of buying a house, you'll do well to shop for an older one. Here's why: As the supply of houses catches up with demand, something has to give—but not the cost of new houses, since building costs remain high. So it's the price of older houses that is gradually coming down—as much as 15 per cent so far, according to a survey by the National Association of Real Estate Boards.

Anti-H.I.P. War Chest

A year ago, the 7,000 doctors of the Medical Society of the County of New York were paying \$15 each for dues. This year, they're being billed for \$30. What's the reason for this 100 per cent boost? [MONA→

For one thing, explains a society spokesman, the doctors' public relations are in for a big expansion. More personnel will be hired; and the Manhattan physicians may sponsor

a number of public health forums.

But that's not the full story. Much of the additional money may go toward launching society President John H. Garlock's special plan for

Dr. Martin Talks Back for Medicine



Pointing his finger at a carping Congressman, A.M.A. President-elect Walter B. Martin maintains that a "distorted picture" is being drawn of America's health needs. "The magnitude of medical . . . problems has been exaggerated," says Dr. Martin, "while actual progress toward solving them has been minimized." On the receiving end of the rebuke: Representative Charles A. Wolverton (R., N.J.), whose sharply critical comments on doctors and the A.M.A. have featured Congressional hearings on the Eisenhower health program.

PANORAMA

establishing a string of medical groups, manned by volunteer physicians, to provide low-cost comprehensive care to poor families. Dr. Garlock's announced aim: to put the Health Insurance Plan of Greater New York (H.I.P.) out of business.

Draft's End in Sight

This may be the last full year of the special doctor draft. By the start of fiscal 1956, says Dr. Howard A. Rusk, chairman of the Government's Health Resources Advisory Committee, the armed forces hope to fill their medical-manpower needs directly from graduating classes of the

medical schools. But before this happens, you can look for the Pentagon to pave the way by:

1. Reducing over-all military manpower (thus eliminating the need for many M.D.s);
2. Cutting the doctor-soldier ratio to 2.9 per 1,000 (just a year ago, it was 3.7 per 1,000); and
3. Establishing military medical scholarships to encourage young doctors to join the regular armed forces.

School Fund Grows

"If every practicing physician in the U.S. contributed just \$25 to medical education this year," says Dr.



STRATEGIST John H. Garlock is raising funds for his plan to put closed-panel medicine out of business in New York City.



MANPOWER ADVISER Howard A. Rusk thinks it may be possible to call off the doctor draft by the middle of next year.

Louis H. Bauer, "we'd raise about \$4 million for the colleges." Too much to expect? Well, says Dr. Bauer—former A.M.A. President, who now heads the American Medical Education Foundation—"we have a much more modest goal for 1954: just \$2 million."

This is a realistic figure, he believes, because more and more doctors are showing an awareness of the schools' needs. Only about 7,200 physicians contributed to the foundation's drive in 1952; but 17,800 took part last year and (including a \$500,000 gift from the A.M.A.) put up \$1.1 million. In addition to the doctors' contributions, almost 1,000

corporations made out \$1.3 million worth of checks to the order of the medical schools.

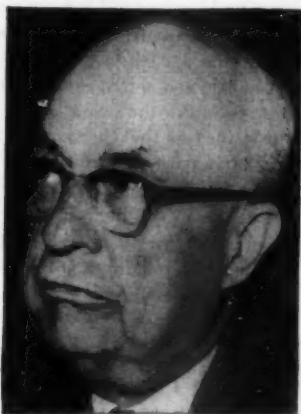
Kaiser Offers Cure-All

Proponents of closed-panel medicine hope to make this a big year. Industrialist Henry J. Kaiser, for instance, apparently has ambitious plans for extending his Pacific Coast Kaiser Foundation (formerly known as Permanente). His new proposal: a national string of 1,000 health centers, staffed by 30,000 doctors, set up to give comprehensive care to 30 million persons for as little as \$3.25 a month.

[MORE→



FUND-RAISER Louis H. Bauer has asked his fellow physicians to ante up \$2 million for medical education this year.



TYCOON Henry J. Kaiser's latest health scheme calls for a nationwide string of closed-panel plans. Initial cost: \$1 billion.

PANORAMA

About \$1 billion in private capital would put the plan in business, says Kaiser. What's more, he declares, his program would dispel the threat of socialized medicine and provide doctors with incomes of at least \$20,000 a year.

Similar—though far more limited—projects are being studied in some areas of the country. A committee of Milwaukee citizens, for example, is exploring the possibility of setting up a carbon copy of Dr. George Baehr's Health Insurance Plan of Greater New York (H.I.P.).

Chiropractors Try Anew

Forty-four states now license chiropractors; and one of the holdouts—New York—seems to be in for another legislative battle on the subject. Just a year ago, the New York legislature rejected a licensing bill by a close vote. But the defeat was partly due to the fact that the state's 2,500-odd chiropractors were split between two organizations that could not agree on the measure. They've since buried the hatchet, however, and are now making a strong effort to enlist support for a brand-new licensing bill.

Hospital Costs Rise

The ceiling on hospital costs hasn't yet been sighted, say the nation's top hospital administrators. And though most of them put the blame on soaring payrolls and higher prices

for supplies, at least one insists that doctors are partially responsible. His contention: The physician's mounting use of new drugs, new techniques, and technical help is forcing hospital costs to rise at least 4 per cent a year.

Others point made by the administrators, according to a survey taken recently by the American Hospital Association:

¶ Doctor-hospital relations are on the mend, thanks largely to the efforts of such agencies as the Joint Commission on the Accreditation of Hospitals.

¶ The rural hospital-bed shortage has been largely licked. In fact, in some administrators, Hill-Burton funds are now needed mainly in urban areas.

New Cooling System

The dealer who sold you room air conditioners for your office now hopes to interest you in a unit that will cool your whole house. Such units (offered so far by only one company) work through the ducts of any forced warm-air heating system. For \$900 (including installation), you can get a unit big enough to cool an average three-bedroom home.

Legion Thrust Parried

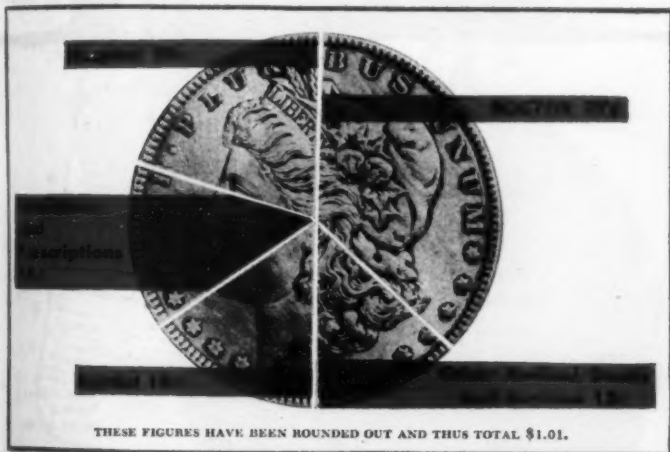
Indications are that there may be rough play in the months ahead as the American Legion battles the

doctors over the shape of Veterans Administration medicine. One straw in the wind: The Legion recently made big, black headlines with the sensational charge that Colorado M.D.s and newsmen had signed a secret "contract" making it "virtually impossible" for the veterans to get fair treatment in the public press.

The truth of the matter—quickly

supplied by the doctors and editors—turned out to be unsensational. The "contract" was merely a six-year-old code of cooperation, worked out openly by the state medical society and the newspapers to insure accurate coverage of medical developments. The Legion's accusation, declared two Denver editors, is "ridiculous."

How the Nation's Health Dollar Is Spent



The nation's annual health bill is \$10.2 billion; of this, doctors' fees add up to \$3.8 billion, and hospital charges amount to about \$2 billion. But the hospitals are far more successful than the M.D.s at collecting money owed them. One reason: About half their bill is automatically paid by insurance companies, whereas only 13 per cent of the doctors' charges is similarly covered. These figures have been released by the Health Information Foundation, whose recent survey of U.S. medical costs is the first comprehensive study of its kind in twenty years. (A full discussion of the report is carried elsewhere in this issue.)

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★ Travert 10%-Electrolyte No. 3	63.0	17.5	—	50.0	25.0	—	6.0	12.5	Travert 10%	Any
Ammonium Chloride 2.14%	—	—	—	150.5	—	70.0	—	—	Travert 10%	Any
Darrow's	121.0	35.0	—	400.0	—	400.0	—	—	Travert 10%	Any
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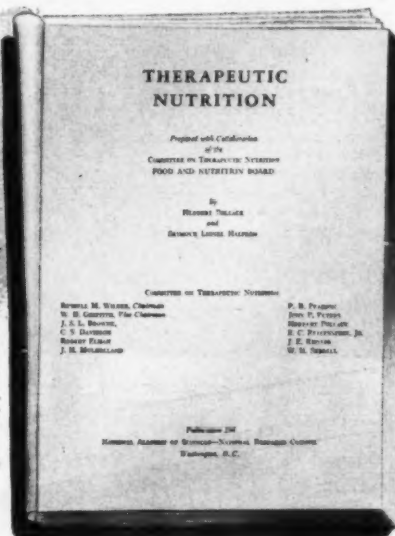
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*Therapeutic Nutrition, Publication No. 234,
National Research Council.*

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1. Boland, E. W.: Ann. Rheum. Dis. 12:125, 1953.

2. Boland, E. W., and Headley, N. E.: J.A.M.A. 148:901, 1952.

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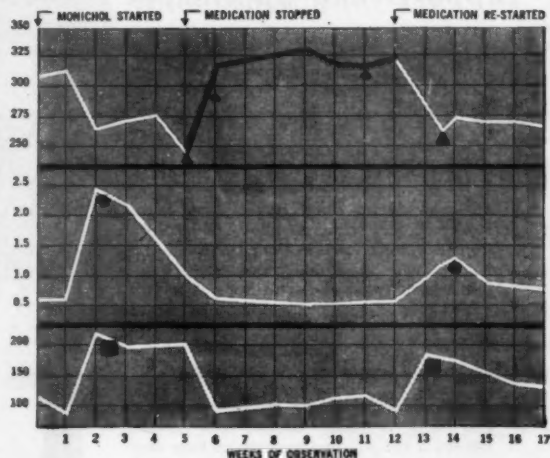
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**Sherber, D. A., and Levites, M. M.: Hypercholesteremia. Effect on Cholesterol Metabolism of a Polyorbate 80-Choline-Inositol Complex (MONICHOL) J.A.M.A. 152:682 (June 20) 1953.

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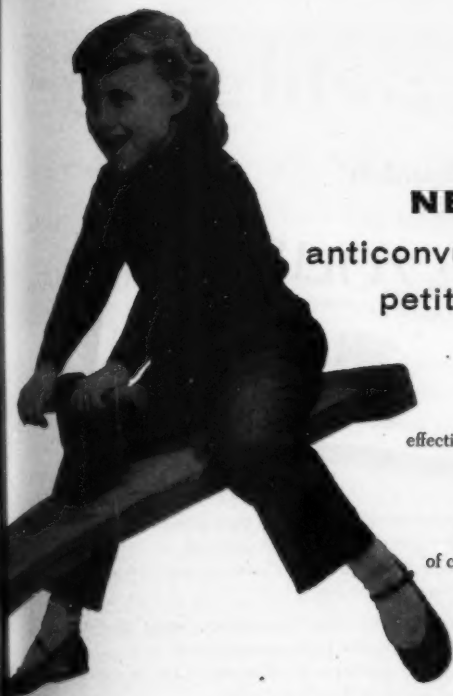
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"To date MILONTIN is the most effective succinimide we have tested....

"...it has the advantage of being relatively nontoxic.

"...more efficacious in that group of cases in which standard medication gave only indifferent-to-fair results, as well as in those cases having the lowest frequency of pretreatment seizures."*

*Zimmerman, E. T.:
Am. J. Psychiat. 109:767, 1953.

MILONTIN® KAPSEALS®
(METHYLPHENYLSUCCINIMIDE, PARKE-DAVIS)



MILONTIN, a drug of choice for petit mal epilepsy, was developed by the research laboratories of Parke, Davis & Company following 11 years of study and clinical investigation.

It is available in 0.5 Gm. Kapseals in bottles of 100 and 1000.



Parke, Davis & Company
DETROIT, MICHIGAN

in arthritis
and allied disorders

BUTAZOLIDIN

(brand of phenylbutazone)



potent, non-hormonal antiarthritic agent

Its therapeutic effectiveness substantiated by more than fifty published reports, BUTAZOLIDIN has recently received the Seal of Acceptance of the Council on Pharmacy and Chemistry of the American Medical Association.

In the treatment of arthritis BUTAZOLIDIN produces prompt relief of pain. In many instances relief of pain is accompanied by diminution of swelling, resolution of inflammation and increased freedom and range of motion of the affected joints.

BUTAZOLIDIN is indicated in:

Gouty Arthritis	Rheumatoid Arthritis
Psoaric Arthritis	Rheumatoid Spondylitis

Painful Shoulder (including peritendinitis, capsulitis, bursitis, and acute arthritis)

Since BUTAZOLIDIN is a potent agent, patients for therapy should be selected with care; dosage should be judiciously controlled; and the patient should be regularly observed so that treatment may be discontinued at the first sign of toxic reaction.

Physicians unfamiliar with the use of BUTAZOLIDIN are urged to send for complete descriptive literature before employing it.

BUTAZOLIDIN® (brand of phenylbutazone), coated tablets of 100 mg.



GEIGY PHARMACEUTICALS

Division of Geigy Chemical Corporation
230 Church Street, New York 11, N. Y.

In Canada: Geigy Pharmaceuticals, Montreal

Sidelights

Saving your records from a

fire • Industrial doctor asks fair treatment • Why not 'generalist' as well as specialist? • P.R. means Personal Responsibility • M.D.s hesitate to speak out on Social Security

In Case of Fire . . .

An article about fire insurance, in this issue, refers to the need of keeping a complete, up-to-date inventory of all items covered by your personal-property, household-furnishings, and office-equipment policies.

Good point, too.

But it reminds us of a practitioner we heard about some time ago whose foresight in this respect was a model: He recorded the price of every purchase made for his home or office. He consulted his broker periodically about how much to knock off for depreciation on the various items. He revised his inventory every year. And he never threw away a sales slip or check stub.

One day, of course, the inevitable happened: A fire broke out.

Our hero immediately began to pat himself on the back for having exhibited such prudence. Now, all he had to do was show the insurance company his inventory and collect on his policies.

But—you guessed it—he had left

the inventory in his desk drawer. And the desk, like everything else, had gone up in flames.

The moral of this story: At least file a carbon copy of said inventory in your safe deposit box at the bank.

The Industrial Doctor

As industrial practice continues to grow in stature and importance, the old reluctance among private physicians to accept the industrial M.D. on equal terms is fast evaporating.

But there are still some wet spots. Just the other day a doctor in a pipe fabricating plant told us this story:

"I treated a worker who had sliced his hand badly on a piece of jagged pipe. Before I sent him on his way, I told him to pay me a return visit in a couple of days so I could examine the wound and change the dressing.

"He failed to come back as instructed. But about a week later I had another caller instead:

"One of our vice presidents rushed into the dispensary to tell me that

AH

Tet

*Afebrile →
In
Hours



"...reports on its use in patients with pneumococcal pneumonia, surgical infections, or urinary tract infections indicate that the oral administration of tetracycline is followed by rapid clinical response. Symptoms, including fever, largely cleared up within 24 to 48 hours."

1. English, A. R., et al: *Antibiotics Annual* (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.
2. Finland, M.: *Brit. M. J.* 2:4846 (Nov. 21) 1953.

BASIC chemically

The structure of this **newest** antibiotic represents a nucleus of modern broad-spectrum antibiotic activity.

BASIC clinically

This **newest** broad-spectrum antibiotic has a wide range of action against respiratory, gastrointestinal, soft-tissue, urinary and mixed bacterial infections due to pneumococci, streptococci, staphylococci and other gram-positive and gram-negative organisms.

"Data thus far available would indicate that the use of tetracycline is accompanied by a significantly lower incidence of gastrointestinal symptoms..."

This **newest** broad-spectrum antibiotic may often be used with good success in patients in whom resistance or sensitivity to other forms of antibiotic therapy has developed.

tetracycline

hydrochloride

brand of TETRACYCLINE hydrochloride

BASIC among broad-spectrum antibiotics

supplied:

TETRACYN TABLETS (sugar-coated)
250 mg., 100 mg., 50 mg.

TETRACYN INTRAVENOUS
Vials of 250 mg. and 500 mg.

TETRACYN ORAL SUSPENSION (amphoteric)
(chocolate-flavored)
Bottles of 1.5 Gm.; provides 250 mg.
per 5 cc. teaspoonful.



J. B. ROERIG AND COMPANY, Chicago 11, Illinois

SIDELIGHTS

the man's hand had become badly infected, that he claimed it was all my fault, and that he was threatening to sue the company.

"When I investigated, I found that the man hadn't visited me again because he had thought his hand was healing satisfactorily, and he didn't want to bother. Came the weekend, though, and his wound began to throb; so he hurried over to his family physician.

"The latter, in the course of treating him, apparently made some caustic remarks about the 'stupidity' of 'company doctors.'

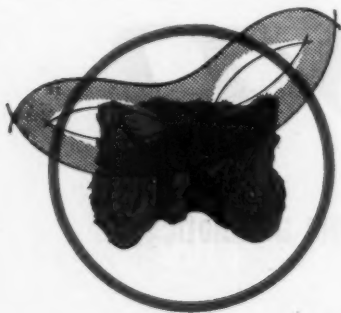
"Now, any practitioner with a brain in his head could have seen that this hand infection would have been taken care of had the patient

only returned to my office as ordered. But my critical colleague in this case wasn't one to miss a chance to knife industrial doctors generally and me in particular.

"Would he have made similarly discouraging remarks about treatment given by another private physician? You guess! Just because I specialize in industrial medicine, he apparently felt he could suspend the rules of ethics.

"It's time men like this learned that we industrial practitioners studied the same books and swore by the same oath as they. Perhaps we just remember that oath a bit more clearly."

Judging from this doctor's story—and from others like it—we're not in-



**Relief of Hemorrhoids without
masking serious pathology**

ANUSOL®

Hemorrhoidal Suppositories

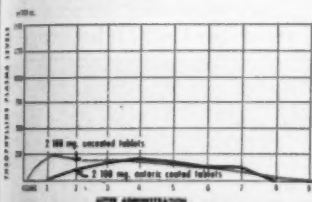
**Without anesthetics or analgesics, Anusol
provides fast and prolonged relief from
itching and pain**

WARNER-CHILCOTT
Laboratories **NEW YORK**

Higher sustained blood levels achieved by Cardalin tablets than with I.V. therapy—with complete safety

Even 3 gr. are not enough

The relative ineffectiveness of 3 gr. aminophylline tablets, given twice daily, is explained by the low theophylline blood levels that they produce. These low oral blood levels also help to explain the great disparity of results obtained with intravenous versus oral aminophylline administered in customary small doses. Intravenous aminophylline has been shown to give suitable results in the management of certain cardiac and respiratory conditions.



Blood theophylline levels following ingestion of enteric coated and uncoated aminophylline (Adapted from Waxler & Schack, J.A.M.A. 143: 736, 1950)

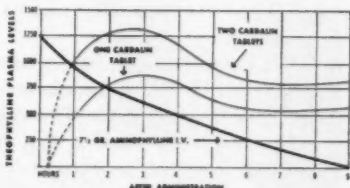
Blood levels obtained with either uncoated or enteric coated 3 gr. aminophylline tablets are approximately half of those produced by 3 gr. of aminophylline I.V.—and approximately $\frac{1}{4}$ of those obtained with the preferred dosage form of $7\frac{1}{2}$ gr. of aminophylline I.V.

Cardalin

produces a full therapeutic effect orally.

One or two Cardalin tablets, given orally, produced higher and more sustained theophylline blood levels

than $7\frac{1}{2}$ gr. of aminophylline intravenously. The high theophylline blood level is responsible for the excellent clinical results obtained with oral Cardalin in bronchial asthma, cardiac conditions, and edematous states.



Sustained plasma theophylline levels were higher with 1 or 2 oral Cardalin tablets than with $7\frac{1}{2}$ gr. of aminophylline I.V.

(Adapted from Bickerman, H. A., et al.: Ann. Allergy 11: 301, 1953, and Truitt, E. B., Jr., et al.: J. Pharmacol. & Exper. Therap. 100: 309, 1950)

Each Cardalin Tablet contains:

Aminophylline 5.0 gr.
Aluminum Hydroxide 2.5 gr.
Ethyl Aminobenzoate 0.5 gr.

Supplied: Bottles of 50, 100, 500 and 1000. Also available: Cardalin-Phen, containing $\frac{1}{4}$ gr. phenobarbital per tablet.

IRWIN, NEISLER & COMPANY
DECATUR, ILLINOIS

Cardalin

PATENT PENDING

tablets

SIDELIGHTS

clined to believe that discord between private and industrial physicians will be eliminated altogether. The thing that will *reduce* it, we predict, is growing understanding of the effect of loose talk on malpractice insurance rates.

Meet the 'Generalist'

In his latest book, "Doctors, People, and Government" (reviewed in this issue), Dr. James Howard Means speaks of the specialist and the "generalist."

The latter synonym for "general practitioner" is seldom heard. Yet it does have the great virtue of brevity.

The main drawback is that its meaning may not be immediately

clear to everyone. But this can overcome if we all adopt the term and use it regularly.

How about that?

Personal Responsibility

The term "P.R." has fast established itself in our daily vocabulary. First of course, stands for public relations.

But more important than the words it stands for is what it means.

A spokesman for the Medical Society of New Jersey points out that what P.R. really means is *Personal Responsibility*—accepting full personal responsibility for the patient's medical needs.

And where does this personal responsibility begin? It begins right

In hypertension . . .

A safer tranquillizer-antihypertensive

Serpasil

A pure crystalline alkaloid of Rauwolfia serpentina

No other rauwolfia product offers such

Unvarying potency / Accuracy in dosage / Uniform results

C I B A



Tablets 0.25 mg. and 0.1 mg.

You wouldn't prescribe 400 eggs a day!

But it would take about
that many eggs to equal
the 25 mg. thiamine
content of a single capsule of
"Beminal" Forte with Vitamin C.

Also included are therapeutic amounts of

B complex factors as well as ascorbic acid
which render this preparation particularly
suitable for use pre- and postoperatively,
and whenever high B and C vitamin
levels are required.

No. 817—Each capsule contains:
Thiamine HCl (B_1) 25.0 mg.
Riboflavin (B_2) 12.5 mg.
Nicotinamide 100.0 mg.
Pyridoxine HCl (B_6) 1.0 mg.
Calc. pantothenate 10.0 mg.
Vitamin C (ascorbic acid) 100.0 mg.

Supplied in bottles of 30, 100, and 1,000.

Suggested dosage:
One to 5 capsules daily or more.



"BEMINAL" FORTE
with **VITAMIN C**

Ayerst, McKenna & Harrison Limited • New York, N. Y. • Montreal, Canada



...check itching and scales
for 1 to 4 weeks

Have you prescribed SELSUN for them yet?
Here are the results you can expect:
complete control in 81 to 87 per cent of
all seborrheic dermatitis cases, and in 92
to 95 per cent of common dandruff cases.
SELSUN keeps the scalp scale-free for one
to four weeks—relieves itching and burn-
ing after only two or three applications.

..... Your patients will find SELSUN
remarkably easy to use. Applied and
rinsed out while washing the hair, it
takes little time, no complicated
procedures or messy ointments. Ethically
advertised and dispensed only on your
prescription. In 4-fluidounce
bottles with directions on label. Abbott

prescribe

SELSUN®

SULFIDE Suspension

(Selenium Sulfide, Abbott)



1-91-54

SIDELIGHTS

the doctor's own office—right in *your* office, he says.

Good public relations, viewed in this light, is no vague, theoretic goal. It's definite. It's down to earth. And, when thought of as Personal Responsibility, it implies just one aim:

To do all those things that encourage, and to avoid all those things that discourage, the affection and esteem of the public.

Fear of Speaking Out

A medical society officer remarked to us recently that "Many of our members who favor Social Security extension would never in a hundred years admit it in the presence of their colleagues."

This wariness is a rather common phenomenon. For example: A number of physicians who told *MEDICAL ECONOMICS* not long ago that they thought doctors should be covered by Old-Age and Survivors Insurance added emphatically, "But don't quote me!"

It's not surprising, because of this skittishness, that in two national surveys made by *MEDICAL ECONOMICS* (which is known to be unofficial and independent), opinion on Social Security extension was divided about 50-50—and that in another survey made by a state medical society, replies (sent to the society's headquarters office) showed opposition to Social Security coverage in a ratio of almost 6-1.

A safer tranquillizer-antihypertensive

No other rauwolfia product offers such

unvarying potency / Accuracy in dosage / Uniform results

Serpasil

A pure crystalline alkaloid of Rauwolfia serpentina

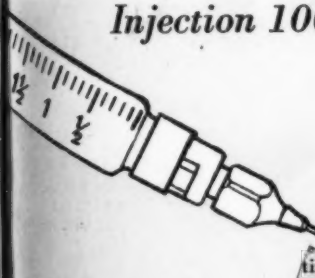
CIBA

Tablets 0.25 mg. and 1 mg.

prevent reactions
to penicillin
and other parenterals

CHLOR-TRIMETON

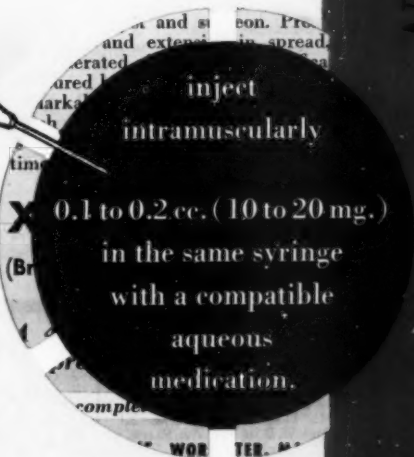
Injection 100 mg./cc.



Packaging: CHLOR-TRIMETON
Injection 100 mg./cc.,
2 cc. multiple-dose vials.

CHLOR-TRIMETON® Maleate,
brand of chlorprophenpyrid-
amine maleate.

Schering



CHLOR-TRIMETON

Injection 100 mg./cc.

CORICIDIN

... complicated colds

CORICIDIN with Penicillin G

PROCAINE

150,000 units

... simple colds

CORICIDIN

... pain

CORICIDIN with Codeine*

($\frac{1}{4}$ or $\frac{1}{2}$ grain)

CORICIDIN

Each CORICIDIN Tablet contains CHLOR-TRIMETON® Maleate, aspirin, acetophenetidin, and caffeine.

Subject to
Federal Narcotic Regulations

Schering

*Codeine,® antihistamine - analgesic
antipyretic compound.

XUM

time

the fourth dimension

PREFERRED local

PASSIVE PAST

ACTIVE FUTURE

QUICK-ACTING



Stocked by leading wholesale druggists and surgical supply houses as a 1/2%, 1% or 2% solution without Epinephrine and with Epinephrine 1:100,000. 2% solution is also supplied with Epinephrine 1:50,000. All solutions dispensed in 50cc. and 30cc. multiple dose vials, packed 500cc. or 5x25cc. to a carton.

Xylocaine® Hydrochloride (Astra) merits special consideration by the busy anesthesiologist and surgeon. Profound in depth and extensive in spread, its well-tolerated effect is more significantly measured by the time saved through its remarkably fast action, by which so much normally wasted "waiting time" is converted to productive "working time".

XYLOCAINE® HCL

Pronounced Xi lo'cain

(Brand of lidocaine hydrochloride*)

AN AQUEOUS SOLUTION

A 4th dimensional approach to preferred local anesthesia

Write Department G4 for complete bibliography



ASTRA PHARMACEUTICAL PRODUCTS, INC. WORCESTER, MASS. U.S.A.

*U.S. Patent No. 2,441,478

fast-acting salicylate formula
HIGH in analgesic power
LOW in risk to the patient

Recent studies^{1,2} suggest that the time-tried salicylates exert a hormonal action similar to that of ACTH, stimulating release of cortisone.

Whenever rapid and sustained salicylate action is desired, **ELPAGEN** gives your patient the benefits of a *potentiated* salicylate combination in *uncoated* tablet form—without the gastric irritation of unmodified salicylates and without the potential dangers (or expense) of ACTH or cortisone itself.

ELPAGEN PATCH

Each orange-colored, uncoated tablet provides:

Sodium salicylate... 5 gr. (325 mg.)	}	POTENTIATED SALICYLATE BLOOD LEVELS
Sodium para-aminobenzoate.... 3 gr. (195 mg.)		
Salicylamide..... ½ gr. (32.5 mg.)		
<i>plus</i>		
Ascorbic acid..... 30 mg. (as sodium ascorbate)	}	SAFEGUARD AGAINST VITAMIN C DEPLETION AND CAPILLARY HEMORRHAGE
Dihydroxy aluminum aminoacetate..... ½ gr. (32.5 mg.)	}	BUFFERING ACTION OVERCOMES GASTRIC INTOLERANCE³
SUPPLIED in bottles of 100 and 500 tablets.		

SUPPLIED in bottles of 100 and 500 tablets.

1. Van Cauwenberge, H.: *Lancet* 261:374, 1951; Van Cauwenberge, H., and Heughebaert, C.: *Proc. Soc. Exper. Biol. & Med.* 80:51, 1952. 2. Palloja, M.: *Lancet* 1:233, 1952. 3. Paul, W.D., et al.: *J. Am. Pharm. A., Scient. Ed.* 39:21, 1950.

THE E. L. PATCH COMPANY
 STONEHAM • MASSACHUSETTS

Bacitracin . . . Neomycin— "the best of the newer local antibiotics"¹
plus Phenylephrine— widely preferred vasoconstrictor

for nasal and sinus infections

White's

DU-BIOTIC INTRANASAL

ANTIBACTERIAL —potent (frequently synergistic) effect of combined bacitracin-neomycin against all common gram-positive and gram-negative bacteria. No systemic side effects—virtually no sensitivity reactions.

DECONGESTIVE —rapid, prolonged decongestive action—without rebound congestion—of the time-tested vasoconstrictor, phenylephrine hydrochloride. Provides symptomatic relief—assures full antibiotic efficacy at site of infection.

Supplied: When constituted by the pharmacist, dropper bottles contain 15 cc. of an isotonic solution at physiological pH which retains its antibiotic potency for three weeks at room temperature.

Also available: *Du-biotic Troches* (Neomycin-Bacitracin)—for relief of throat infections.

1. Poole, W. L.: Discussing Forbes, M. A. Jr., Clinical Evaluation of Neomycin in Different Bases, Southern M. J. 45:235 (March) 1952.

Now available in either spray package or dropper bottle.

White Laboratories, Inc., Kenilworth, N. J.



Thank you doctor
for telling mother about..



⊗ The Best Tasting Aspirin
you can prescribe

⊗ The Flavor Remains Stable
down to the last tablet

⊗ Bottle of 24 tablets \$
(2½ grs. each)

We will be pleased to send samples on request

THE BAYER COMPANY DIVISION of Sterling Drug Inc., 1450 Broadway, New York 18, N.Y.



which piston fits this barrel?

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meeney

miny



mo!

VIM

marks another milestone in the history of hypodermic syringes — completely interchangeable VIM barrels and pistons. **NO MORE MATCHING PROBLEMS** — Every piston fits every barrel. Odd pistons and barrels may be combined as usable syringes — a real saving. Furthermore, clear barrels **CAUSE LESS FRICTION AND LONGER SYRINGE LIFE**. Precision fit is guaranteed . . . no leakage, no backfire.



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Presently available in 2 cc size only.
Packaged individually or in units of
ONE DOZEN.

SYRINGES

MACGREGOR INSTRUMENT COMPANY, NEEDHAM 92, MASS.

your patients' "best buy"

in the multiple vitamin market



GELSEALS

'Multicebrin'

(Pan-Vitamins, Lilly)

for economy, potency, and quality

FORMULA

Each gelseal contains:

Thiamin Chloride.....	3 mg.
Riboflavin.....	3 mg.
Pyridoxine Hydrochloride.....	1.5 mg.
Pantothenic Acid (as Calcium Pantothenate).....	.5 mg.
Nicotinamide.....	25 mg.
Vitamin B ₁₂ (Activity Equivalent).....	3 mcg.
Folic Acid.....	0.1 mg.
Ascorbic Acid.....	75 mg.
Distilled Tocopherols, Natural Type.....	10 mg.
Vitamin A Synthetic.....	10,000 U.S.P. units
Vitamin D Synthetic.....	1,000 U.S.P. units

Supplied in 100's and 1,000's. DOSE: One or more daily.

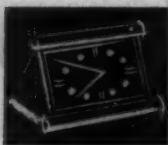
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ELI LILLY AND COMPANY, INDIANAPOLIS 6, INDIANA, U.S.A.

Phospho-Soda (Fleet)[®]

A laxative of choice for half-a-century

GENTLE



PROMPT

THOROUGH



Purgative: 4 teaspoonfuls or more before breakfast.

Aperient or Mild Laxative: 2 teaspoonfuls before breakfast or, if indicated, before other meals.

Administer in one-half glass of water, followed by second glass.

Phospho-Soda (Fleet) is a solution containing in each 100 cc. sodium biphosphate 48 Gm. and sodium phosphate 18 Gm.

C. B. Fleet Co., Inc. • Lynchburg, Virginia

'Phospho-Soda' and 'Fleet' are registered trademarks of C. B. Fleet Co., Inc.

Also Gentle... Prompt... Thorough
THE FLEET ENEMA
in the "squeeze bottle" disposable unit

No. 3 of a series to resolve
SULFA DRUG FACTS

Q. Is the solubility of sulfa
drugs important?

Yes, next to potency.

A.

The council-accepted Triple Sulfas (Meth-Dia-Mer Sulfonamides) is readily soluble throughout the urinary pH range. Of particular importance, however, Triple Sulfas is more soluble than other sulfonamides at pH 5.5 or lower, where crystalluria is most likely to occur.

Triple Sulfas (Meth-Dia-Mer Sulfonamides) remains unsurpassed among sulfa drugs for Highest potency • Wide spectrum • Highest blood levels • Safety • Minimal side effects • Economy • This is why leading pharmaceutical manufacturers offer Triple Sulfas to the medical profession.

This advertisement is presented on their behalf by

Calco Chemical Division, AMERICAN Cyanamid COMPANY, Bound Brook, N. J.



"intermediate" sedative

BUTISOL® SODIUM

BUTABARBITAL SODIUM • McNEIL

Onset of action:

15 to 30 minutes after administration

Duration:

five to six hours

Well tolerated:

in hypertension...kidney disease...
cardiovascular and
gastrointestinal disorders...anxiety states.

Tablets imprinted, 'McNeil'

Samples available on request

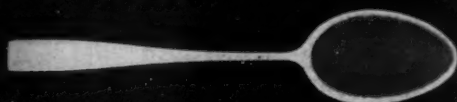
McNEIL

LABORATORIES, INC.
PHILADELPHIA 32, PENNSYLVANIA

here
are
the
dosage
forms
of

BUTISOL SODIUM

INTERMEDIATE SEDATIVE



Green

ELIXIR

0.2 Gm. (3 gr.) per
30 cc. (1 fl. oz.)



Lavender

CAPSULE

0.1 Gm. (1½ gr.)



Pink

TABLET

0.1 Gm. (1½ gr.)



Orange

TABLET

50 mg. (¾ gr.)



Green

TABLET

30 mg. (½ gr.)



Lavender

TABLET

15 mg. (¼ gr.)



HEALTHY APPETITE ...HAPPY CHILD



MULTI-BETA® B₁₂ DROPS

Each 1 cc. (20 drops) contains:

Crystalline Vitamin B ₁₂	10 mcg.	Nicotinamide	10 mg.
Thiamine hydrochloride	2.5 mg.	Pyridoxine hydrochloride	0.15 mg.
Riboflavin	2.0 mg.	Panthenol	0.2 mg.

Freely soluble in milk, fruit juice, formulas. 15 cc. and 50 cc. bottles, with dropper.

WHITE LABORATORIES, INC., KENILWORTH, N. J.



PHOTOGRAPH BY RUZZI GREEN

When the reflection reflects on your patient, suggest

'MELOZETS'

METHYLCELLULOSE WAFERS*

You can help your overweight patients look better and feel better by recommending 'MELOZETS,' the methylcellulose wafers that look and taste like graham crackers.

A "drugless" help to any reducing regimen, each 'MELOZETS' wafer gives a sense of satisfying fullness, blunts the appetite, yet supplies only about 30 calories.

Easy to eat: One wafer with a glass of fluid between meals or one-half hour before meals . . . up to 8 wafers a day.

Supplied: By pharmacists in 1/2-lb. boxes of approximately 25 wafers.

FREE DIET SHEETS

For a pad of 42 reducing menus and sample 'MELOZETS,' write Professional Service Dept., Sharp & Dohme, West Point, Pennsylvania. *Patent applied for.

FOR RAPID AND
SUSTAINED RELIEF IN

bronchial asthma

HP*ACTHAR Gel meets the practical requirements for successful treatment of bronchial asthma in the patient's home and the physician's office. The need for hospitalization is greatly reduced, even in severe cases.

HP*ACTHAR Gel acts rapidly—essential in the acute paroxysms of asthma. Therapeutic action is sustained over prolonged periods of time, resulting in a diminished need for injections: One or two per week suffice in many instances.

HP*ACTHAR Gel can be a life-saving measure in status asthmaticus. Remissions up to 18 months duration have been reported.

HP*ACTHAR Gel

*Highly Purified

HP*ACTHAR Gel is The Armour Laboratories Brand of Purified Adrenocorticotrophic Hormone—Corticotropin (ACTH).

Subcutaneously
or intramuscularly as desired
with Minimum Discomfort

Home and Office Treatment
Greatly Simplified
Significant Economy



THE ARMOUR LABORATORIES
A DIVISION OF ARMOUR AND COMPANY • CHICAGO 11, ILLINOIS



Letters

Tax deductions for expenses in relocation • Join forces with the osteopaths? • How not to be a doctor's wife • Telephone appeals for money • Suggested cures for fee splitting • The Bricker Amendment

Death of a Group

Sirs: "Death of a Group" is the best article I've ever read on group practice. It will do much to help group harmony and group success, for the mistakes of others are the best teacher we have. I'd never realized, though, that it's possible to have *all* the mistakes in one group. It's amazing to me that the Cloetta Clinic lasted as long as it did.

John R. Sedgwick

Business Manager, The Medical Group
Honolulu, Hawaii

Sirs: Except that we had only five doctors and the Cloetta Clinic had thirteen, you might have been writing about our group, which was dissolved last spring.

M.D., Pennsylvania

Sirs: It seems to me there were at least three major reasons why the Cloetta Clinic failed:

1. Its members just weren't group-minded. Dr. Gorman and Dr. Denny, for example, should never have been admitted to the group.

2. There was no probationary period for new members. New men should be on a paid compensation basis for, say, two years before being admitted to partnership.

3. Income distribution was based too much on original investment. At Cloetta, each founder evidently got about a \$9,000 annual return on his \$15,000 investment, whereas a set dividend of 7 or 10 per cent would have been more than fair.

It boils down to this: If the Cloetta Clinic had adopted the tried-and-true methods in administration that it undoubtedly did in medical science, it would be flourishing now.

Harry B. Davidson

Manager, The Joslyn Clinic
Maywood, Ill.

Sirs: In my opinion, it's surprising that the Cloetta Clinic lasted as long as it did. The personal characteristics of its founders seem better fitted for a TV series than a medical group.

A general surgeon, an internist, and *four* general practitioners would have formed a more valuable group, particularly if the G.P. section had

Why risk sensitization or resistant organisms by using systemic antibiotics for intranasal application?

Violent sensitization following parenteral administration of a widely used systemic antibiotic, which is also available in nose-drop form. Painted by medical illustrator Paul Peck from actual case.



'DRILITOL'—S.K.F.'s dual antibiotic intranasal preparation—obviates fear of sensitization or resistant organisms to widely used systemic antibiotics.

WITH **'DRILITOL'**, there is no danger of sensitizing the patient to—nor of developing in him organisms resistant to—penicillin or the "mycins", which are so frequently used systemically in serious infections.

'DRILITOL' contains two effective antibiotics
that are not in wide-spread systemic use.

In combination, these antibiotics—anti-grampositive gramicidin
and anti-gramnegative polymyxin—actually potentiate each other.
This important phenomenon results in an enhanced antibiotic
action that attacks the wide spectrum of bacteria commonly
found in intranasal infections.

'DRILITOL' also contains the effective decongestant, Paredrine[†]
Hydrobromide, and the antihistaminic, thenylpyramine
hydrochloride.

for intranasal infections specify:

Drilitol* Solution
or 'Drilitol Spraypak'

Smith, Kline & French Laboratories, Phila.

[†]T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F.

*T.M. Reg. U.S. Pat. Off.

'Spraypak' Trademark

LETTERS

consisted of men already in practice. Patients could thus have had their own "family doctor" in the clinic.

Alexander W. Magocsi, M.D.
York Village, Me.

SIRS: Without a strong element of mutual good faith and respect, the sad tale recounted in your article would certainly be repeated more frequently than it is. But most groups can and do surmount the problems faced by the Cloetta Clinic.

Edwin P. Jordan, M.D.
Executive Director
American Association of Medical Clinics
Charlottesville, Va.

SIRS: In theory, the small group clinic represents the ideal way of practicing modern medicine with all its complexities. But as long as both

patients and physicians are individual human beings with divergent personality patterns, nothing can replace the independent practitioner.

Charles H. Knickerbocker, M.D.
Bar Harbor, Me.

Relocation Expenses

SIRS: "Midwestern G.P.," who was told he could get no income tax deduction for travel expenses in connection with relocation, might be interested in my experience.

A couple of years ago, I came to Wisconsin from the South to scout a medical opening, and wound up taking the job. I was able to deduct my travel expenses for two reasons:

1. As part of my new work, I was to be associated with a cooperative



In Peptic Ulcer management and
in Hyperacidity, the Non-
constipating Antacid Adsorbant

Gelusil®

A pleasant tasting combination of
especially prepared aluminum hy-
droxide gel and magnesium trisilicate

WARNER-CHILCOTT
Laboratories NEW YORK

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NEW YORK

**continued
patient
acceptance**



from the "difficult" first trimester

to the time of delivery



Natalins

*the new **smaller** prenatal capsules*

smaller size

easier to swallow

small dosage

only three capsules daily

Unlike ordinary prenatal capsules, Natalins can be prescribed with assurance of acceptance throughout pregnancy.

Natalins are much smaller, much easier to swallow, and do not aggravate or cause nausea or regurgitation.

Only 3 Natalins daily supply generously protective amounts of vitamins and minerals to supplement the pregnant patient's uncertain food intake.



The Natalins formula:

3 capsules daily supply:

Vitamin A	6000 units
Vitamin D	600 units
Ascorbic acid	100 mg.
Thiamine	3 mg.
Riboflavin	4.5 mg.
Niacinamide	30 mg.
Pyridoxine hydrochloride	0.6 mg.
Calcium pantothenate	3 mg.
Folic acid	1 mg.
Vitamin B ₁₂ (crystalline)	1 mcg.
Iron (from ferrous sulfate)	22 mg.

Purified veal bone ash to supply:
Calcium 375 mg.
Phosphorus 188 mg.

Natalins also contain traces of copper, zinc, manganese, magnesium and fluorine.

All vitamins are in synthetic, hypotensive form.

Supplied in bottles of 100 and 500.

MEAD MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA, U.S.A.



Clinical evidence shows that the addition of a vitamin-mineral supplement to the mother's diet insures better health to both mother and fetus. To help prevent anemias and other metabolic disturbances during pregnancy and lactation, obstetricians prescribe VITANATE routinely.

The new VITANATE formula includes folic acid, vitamin B₁₂ and the intrinsic factor concentrate, which is essential for maximal utilization of orally-administered vitamin B₁₂.

All these vitamins and minerals in a single, pink-coated tablet of VITANATE.

Ferrous Sulfate	1.5 gr.
Dicalcium Phosphate	3.75 gr.
Vitamin D	250 units
Thiamine Mononitrate	0.167 mg.
Riboflavin	0.334 mg.
Nicotinamide	5.0 mg.
Alpha Tocopherol Acetate	
(Vitamin E)	0.34 mg.
Vitamin A	700 units
Folic Acid	0.167 mg.
Vitamin B ₁₂	0.5 mcg.
Intrinsic Factor Concentrate	0.35 mg.

Literature and samples available on request.

CHICAGO PHARMACAL COMPANY

5547 N. Ravenswood Ave.

Chicago 40, Illinois

WESTERN BRANCH NORTHWEST BRANCH

2161 W. Jefferson Blvd.
Los Angeles, Cal.

5513 Airport Way
Seattle, Wash.

LETTERS

hospital. On my preliminary signed a contract for this.

2. As future chief surgeon of the new hospital, I gave advice about instruments and equipment to be purchased in time for my arrival two months later.

Thus, the Internal Revenue Service couldn't contend that my travel expenses resulted "from a practice not yet in existence."

M.D., Wisconsin

D.O.s and Chiropractors

Sirs: I note that Senator William Langer (R., N.D.) is championing chiropractic care for veterans at Government expense.

I was born and raised in North Dakota and have often thought Senator Langer a brilliant lawyer and legislator. It's hard for me to understand how he can possibly endorse the chiropractic cause.

Herbert C. Winge, M.D.
Yankton, S.D.

Sirs: Some of your readers urge that we join with osteopaths to defeat pro-chiropractic legislation. I, too, M.D.s bit on that one a few years back; and now the state is infested with substandard practitioners.

We must never forget that the D.O.s are salesmen, not physicians, and should be treated as such. And I'm not in direct competition with any active osteopath, either!

Charles R. Wilson, M.D.
Manton, Iowa

Sirs: Let's end this purposeless and useless conflict between osteopaths

INCREASINGLY PREFERRED IN ROUTINE

PAIN PROBLEMS

"analgesia without drowsiness..."

"analgesia without depression..."

"analgesia without habituation..."

"analgesia without drenching sweats..."

"analgesia without nausea..."

"analgesia without gastric hemorrhage..."

Strascogesic

- Arthritic Pain
- Headache
- Dysmenorrhea
- Tension Headache
- Low Back Pain
- Migraine
- Colds and Grippe
- Dental Pain
- Post Partum Pain

QUICK ACTING
NON-ACID
NON-NARCOTIC
NON-BARBITURATE

FORMULA

Acetyl-p-aminophenol	300 mg.
Salicylamide	200 mg.
Raphetamine (racemic amphetamine phosphate monobasic)	2 mg.
Metoprine® (methyl atropine nitrate)	0.5 mg.

DOSAGE

Adults: 1 to 2 tablets every 3 to 4 hours

SUPPLIED

In bottles of 100 and 1000

Write for complimentary supply.

Strassonburgh
FOUNDED 1944

E. J. STRASSONBURGH CO., ROCHESTER 14, N. Y., U. S. A.

LETTERS

and M.D.s. Actually, we all have a similar approach to medical problems.

Medicine and osteopathy can best serve the interests of mankind and of the grass-roots doctor by forgetting politics and considering some form of amalgamation. And I believe most of us osteopaths—particularly among the younger men—are prepared to conciliate our professional differences!

Louis V. Rosell, D.O.
St. Louis, Mo.

Another M.D. Prisoner

SIRS: I don't want to detract from the heroism of Capt. William Shadish, whose picture you recently ran; but I'd also like to call to your atten-

tion Capt. Alexander Boysen (the wise of the Army Medical Corps) who was a prisoner in Korea for about the same length of time as Capt. Shadish (nearly three years).

Blair J. Henningsgaard, M.D.
Astoria, Ore.

Advice for Doctor's Wife

SIRS: If doctors were really as Mrs. Marlowe described them in her series on "How to Be a Doctor's Wife," they'd be unbearable snobs. And in order to get along with such men, their wives would have to be timid mice—or dumbbells.

No doctor is God, nor should he be treated as if he were. He's only a human being doing a job. If the doctor himself, knowing his own weak-

rapidly bactericidal against all of the
most common gram-positive pathogens

ILOTYCIN

(ERYTHROMYCIN, LILLY)

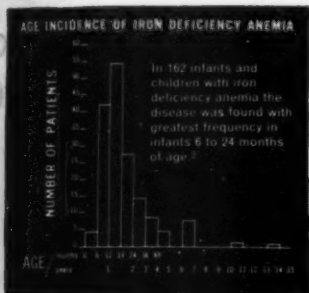
The graphic features a dark rectangular background. On the left is a stylized sunburst or flower-like emblem with multiple pointed petals. To its right, the word "ILOTYCIN" is written in a bold, sans-serif font. Further right, the phrase "the original Erythromycin" is written in a smaller, lowercase sans-serif font. In the bottom right corner of the graphic is the Lilly logo, which consists of the word "Lilly" in a cursive script inside an oval border.

ILOTYCIN the original Erythromycin

Lilly

iron deficiency anemia

"...is encountered particularly in infants..."¹



Iron deficiency, "the most common nutritional deficiency" in infants and children,² is observed frequently after the age of six months.^{1,2} Neither breast milk nor a cow's milk formula provides satisfactory iron intake after the infant's inherited iron stores are exhausted.³

Fer-In-Sol administered regularly gives effective protection against the iron deficiency so prone to develop in infants. In both prophylaxis and therapy, a specific response is obtained with this concentrated solution of ferrous sulfate.

Only 0.3 cc. of Fer-In-Sol supplies the full Recommended Daily Allowance of iron for infants. Best administered in fruit juice or water between feedings, Fer-In-Sol leaves no unpleasant after-taste and is exceptionally well tolerated.



0.3 cc. supplies 37.5 mg. (about 1/2 grain) ferrous sulfate—7.5 mg. iron.

Available in 15 and 50 cc. bottles with droppers calibrated for 0.3 and 0.6 cc.

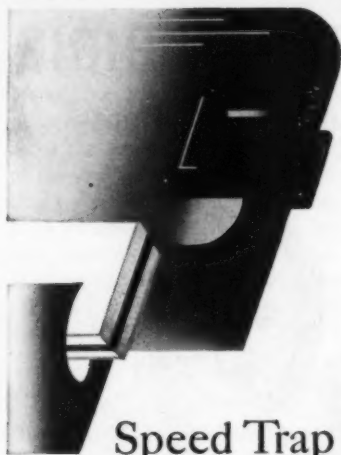
FER-IN-SOL

Iron in a drop for infants and children

1. Wintrobe, M. M.: *Clinical Hematology*, ed. 3, Philadelphia, Lea & Febiger, 1951, pp. 642-643.
2. Smith, N. J., and Rosello, S.: *J. Clin. Nutrition* 1: 278, 1953.
3. Jans, P.C., in *A.M.A. Handbook of Nutrition*, ed. 2, New York, Blakiston, 1951, p. 280.

MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA, U.S.A.

MEAD



Speed Trap

Those who *insist* on hurrying their meals, only to be caught with an attack of acid indigestion, can get the relief they need with BiSoDol.

This fast-acting antacid helps effectively neutralize gastric acidity which causes stomach upset and prevents the immediate return of the disturbance! BiSoDol actually soothes and protects irritated stomach membranes. When you warn your "hurry hurry" patients about gulping their food, why not also tell them about the relief BiSoDol can bring.

fast / acting



/ tablets or powder

WHITEHALL PHARMACAL COMPANY
22 East 40th Street • New York 16, New York

LETTERS

nesses, doesn't have enough humility to understand this, he deserves neither the honorable name of "Doctor" nor the respect of others.

Leo Nadvorney, M.D.
Bronx, N.Y.

Social Worker Protests

Sirs: As a professional social worker, I read Wallace Croatman's recent article, "They Help Patients Meet Their Doctor Bills," with interest. May I make just one slight objection, however?

The author—inadvertently, I'm sure—gave the impression that medical social work offers doctors and patients merely a brisk and businesslike fee-setting and bill-collecting operation. But if it's truly social work, it should offer far more than this; it should aim at easing the social and emotional tensions that have an impact on health.

Adelaide F. Heyman
Arlington, Va.

Charity by Telephone

Sirs: Why must veterans' organizations waste so much of a doctor's time on the telephone? I contribute annually to the Amvets, the Veterans of Foreign Wars, the American Legion, the Military Order of the Purple Heart, etc.—and, believe me, there *are* etc.! But, even so, most of these people call me about every six months.

Usually the phone rings when I'm examining a patient. The caller, Commander So-and-so, refuses to give his message to the office girl; he

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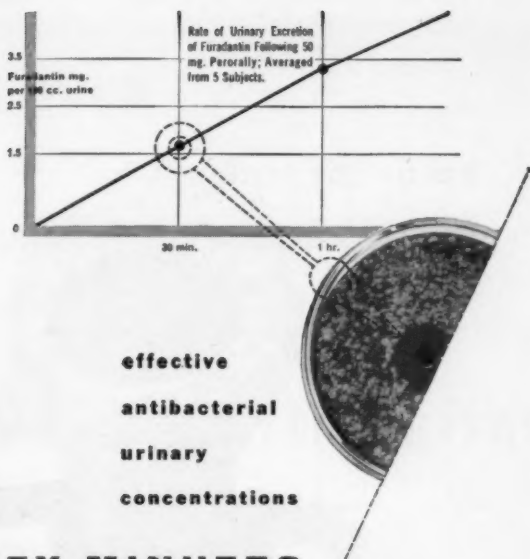
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**effective
antibacterial
urinary
concentrations**

IN THIRTY MINUTES

So remarkable is the affinity of Furadantin for the urinary tract that the urine becomes actively antibacterial within 30 minutes after ingestion, as shown by urinary concentrations and agar plate tests.

Furadantin exhibits an extensive range of antibacterial activity against both gram-positive and gram-negative urinary tract invaders.


Scored tablets of 50 & 100 mg.

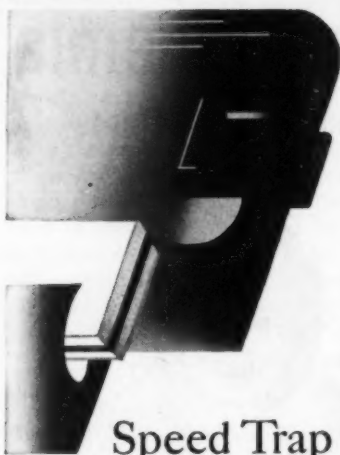
**IN ACUTE
AND CHRONIC
URINARY
INFECTIONS**



LABORATORIES Inc.
NORWICH, NEW YORK



CLASS OF ANTIMICROBIALS  PRODUCTS OF EATON RESEARCH



Speed Trap

Those who *insist* on hurrying their meals, only to be caught with an attack of acid indigestion, can get the relief they need with BiSoDol.

This fast-acting antacid helps effectively neutralize gastric acidity which causes stomach upset and prevents the immediate return of the disturbance! BiSoDol actually soothes and protects irritated stomach membranes. When you warn your "hurry hurry" patients about gulping their food, why not also tell them about the relief BiSoDol can bring.

fast / acting



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LETTERS

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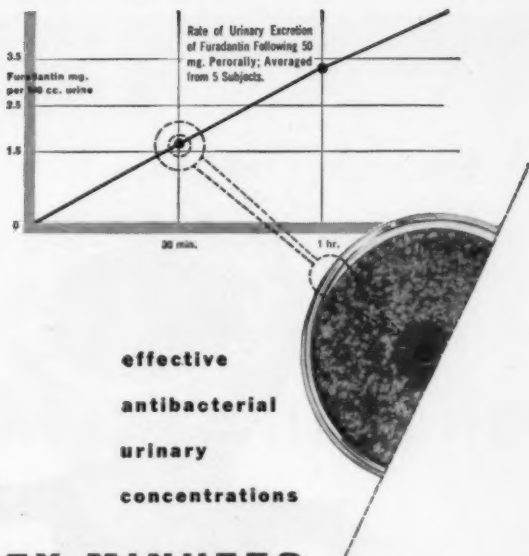
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Furadantin exhibits an extensive range of antibacterial activity against both gram-positive and gram-negative urinary tract invaders.

Scored tablets of 50 & 100 mg.

**IN ACUTE
AND CHRONIC
URINARY
INFECTIONS**



LABORATORIES Inc.
NORWICH, NEW YORK

THE NITROFURANS — A UNIQUE CLASS OF ANTIMICROBIALS  PRODUCTS OF EATON RESEARCH



IMPROVED

**for patients requiring
a combination of antibacterials**

Erythrocin with Sulfas

TRADE MARK

Erythromycin Stearate With Triple Sulfas

The Improved Combination

ERYTHROCIN with SULFAS provides rapid blood levels
... special buffer system assures swift drug absorption
... each component is administered in the established
dosage range ... new Erythromycin form eliminates
need for an enteric coating ... new *Film Sealed**
tablet facilitates easy swallowing, masks
taste of drug. In bottles of 25 and 100. **Abbott**

Each ERYTHROCIN with SULFAS Tablet represents:

ERYTHROCIN (as Erythromycin stearate).....	75 mg.
Sulfadiazine (as sodium salt).....	111 mg.
Sulfamerazine (as sodium salt).....	111 mg.
Sulfamethazine.....	111 mg.
with aluminum hydroxide as buffer	

*patent applied for

LETTERS

insists on talking to the doctor in person. And the patient waits.

I wish other doctors would join me in saying at such times, "Commander, if you want my contribution, write, don't phone." If enough of us took this stand, we might eventually get results.

M.D., New York

Fee-Splitting Cures

SIRS: Until the surgeon accepts the G.P. as a full professional partner, clandestine fee splitting in one form or another will continue to plague us.

Leon Henri Goldberg, M.D.
Nyack, N.Y.

SIRS: Fee splitting prevails because there's something to split. Surgical fees are out of proportion to all other charges in medicine—and the fact that so many surgeons will pay a rebate proves this.

If all surgery were done at Blue Shield rates, there wouldn't be any fee splitting, because there wouldn't be any fees to split (and many a woman would still have her uterus).

M.D., Indiana

Specialists as Teachers

SIRS: One flaw in modern medical education is too seldom mentioned: Most teachers are specialists, not all-around family doctors. Thus, each instructor, focusing on a tiny portion of the anatomy, fails to present the whole man to his students.

Besides, as more and more teachers clamp onto university payrolls,

fewer and fewer come from the ranks of private practice. These salaried M.D.s just can't be expected to understand and reflect the problems of the independent solo doctor.

M.D., Maryland

The Bricker Controversy

SIRS: I was surprised that you carried an article by Senator Bricker in support of what's known as the Bricker Amendment. It dealt with a most controversial matter; yet there was no indication to that effect, nor any attempt to show the opposite side. This isn't the kind of journalism we've come to expect from your magazine.

George W. Naumburg Jr., M.D.
Scarsdale, N.Y.

MEDICAL ECONOMICS doesn't necessarily uphold the views of individual contributors. While the editors welcome the chance to explore every aspect of controversial questions, it isn't always possible to do so in a single issue.—Ed.

Caste System?

SIRS: In this supposedly democratic country of ours we're gradually creating a specially privileged caste: the veterans.

Under the U.S. Civil Service, for example, the veteran is given extra points that help him score well on his exams. Even if his score is low, he's usually hired because of the rule that *all* veterans be given priority, no matter how high the grades of their competitors. [MORE→]

PRENATAL

CAPSULES



Prenatal Capsules Formula
Each capsule contains:
Vitamin A..... 2,000 U.S.P. Units
Vitamin D..... 400 U.S.P. Units
Thiamine Hydrochloride (B₁)..... 2 mg.
Riboflavin (B₂)..... 2 mg.
Niacinamide..... 7 mg.
Vitamin B₁₂..... 1 microgram
as present in concentrated
extractives from streptomyces
fermentation

PRENATAL Capsules
Lederle provide, in truly
adequate amounts,
all the vitamins,
minerals, calcium and
iron needed for tissue
nutrition and blood
formation during
pregnancy and lactation.
One capsule, one to
three times a day,
protects against
deficiencies.

- Vitamin K (Menadiolone).....0.5 mg.
- Ascorbic Acid (C).....35 mg.
- Manganese† (in MnSO₄).....0.12 mg.
- Folic Acid.....1 mg.
- Calcium (in CaHPO₄).....250 mg.
- Phosphorus (in CaHPO₄).....190 mg.
- Dicalcium Phosphate
- Anhydrous (CaHPO₄).....969 mg.
- Iron (in FeSO₄).....6 mg.
- Ferrous Sulfate Exsiccated.....20 mg.

†The need for manganese in human
nutrition has not been established.

GRAVIDOX*

Pyridoxine-Thiamine Hydrochloride

For prompt relief of primary
nausea and vomiting of pregnancy.
Tablets or solution.



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AMERICAN Cyanamid COMPANY

30 Rockefeller Plaza, N.Y. 20, N.Y.

*Reg. U. S. Pat. Off.

DIABETES

"The ideal detection center is the office of the family physician."
20,255 "new" diabetics were found in one year
by 5000 physicians responding to a recent nationwide poll.

Blotner, H., and Marble, A.: *New England J. Med.* 245:567 (Oct. 11) 1951.

CLINITEST® for detection of urine-sugar

Ames Diagnostics
Adjuncts in clinical management



AMES
COMPANY, INC.
ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

Or take the matter of disability benefits. I recently examined one veteran who was supposed to be 30 per cent disabled because of acne. Another was paid for 75 per cent disability because of preinduction valvular heart disease (his military service had consisted of one month's training and five months in the hospital).

The Government might as well go even further. Why doesn't it subsidize the veterans when they need money for legal services in criminal cases, for advice of investment counselors, and for plumbing repairs in homes they bought with the help of the Government?

M.D., Illinois

Reciprocity

SIRS: The Senate, I hear, has ratified treaties granting foreign physicians full reciprocity in all states that don't ban aliens from practicing medicine.

Must an American citizen acquire a foreign medical license, then, in order to get equal privileges?

Alfred R. Ross, M.D.
Wellsville, N.Y.

Chirose' Ads

SIRS: A couple of days ago, I was reading in *MEDICAL ECONOMICS* that the Colorado state board of chiropractic had passed "a stiffly worded resolution" against flamboyant advertising. Almost at that very moment, my nurse handed me the latest piece of literature put out by the Spears Chiropractic Hospital here in

reflects in your patients
a fresh response
and a
vigorous
improvement

armatinic
activated

Vitamin B₁₂ PLUS Intrinsic Factor

In Armatinic Activated, the hemopoietic factors activate and potentiate each other in their interrelated role in producing mature red blood cells.

Each ARMATINIC ACTIVATED Capsulette contains:

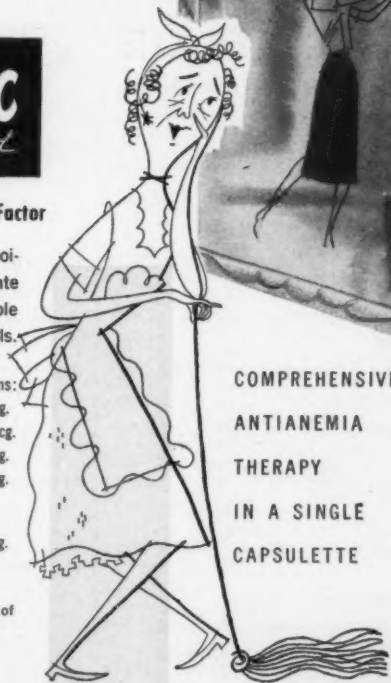
Ferrus Sulfate, Exsiccated.....	200 mg.
Vitamin B ₁₂ Crystalline.....	10 mcg.
Folic Acid.....	1 mg.
Vitamin C.....	50 mg.
Liver Fraction II (N.F.) with Deiccated Duodenum (contains Intrinsic Factor).....	350 mg.

Supplied in bottles of 100 and 1000.

Also available: Armatinic Liquid, bottles of 8 oz. and 16 oz.



COMPREHENSIVE
ANTIANEMIA
THERAPY
IN A SINGLE
CAPSULETTE



THE ARMOUR LABORATORIES
A DIVISION OF ARMOUR AND COMPANY • CHICAGO 11, ILLINOIS

NEW!

the best tolerated, best absorbed form of iron

iron choline citrate (FERROLIP)

now combined with every known basic hemogenic factor

FERROLIP® PLUS

for dramatic response in primary and secondary anemias

Each Ferrolip Plus capsule supplies:

Iron Choline Citrate† (Ferrolip).....	200 mg.
Vitamin B ₁₂ Crystalline, U.S.P.....	10 mcg.
Folic Acid.....	0.5 mg.
Ascorbic Acid.....	50 mg.
Thiamine Hydrochloride.....	2 mg.
Riboflavin.....	1 mg.
Pyridoxine Hydrochloride.....	0.5 mg.
Desiccated Duodenum*.....	100 mg.
Liver—Gastric Tissue*.....	100 mg.

*contains intrinsic factor

†U. S. Patent No. 2575611

1 or 2 capsules t.i.d. Bottles of 100 and 1000.

Also available:

Ferrolip Tablets—bottles of 100 and 1000.

Ferrolip Syrup—pint and gallon bottles.

Ferrolip Drops—bottles of 30 cc.

FLINT, EATON & CO. DECATUR, ILLINOIS

Western Branch: 112 Pomona Ave. • Erea, California

LETTERS

Denver, claiming miraculous "cure" for such diseases as cerebral palsy, "heart trouble," cancer, and multiple sclerosis.

When is the toning-down process going to start?

M.D., Colorado

Fluorine and Iodine

SIRS: I wonder if the doctor who calls fluoridation "compulsory medication" refuses to eat iodized salt. Same principle, isn't it?

R. G. Kroeze, M.D.
Butte, Mont.

Pay Scale at the V.A.

SIRS: The discussion of radiology as a specialty, which appeared in the January MEDICAL ECONOMICS, states that the Veterans Administration pays its radiologists \$12,000 a year. A slight correction: The V.A. will pay \$12,000 a year to a *board-diplomated* radiologist with *seven or more years of experience*.

V.A. Doctor, Virginia

Overprescribing

SIRS: A couple of years ago, a patient who had been under the care of a well-known specialist brought me several jars of tablets he had prescribed for her. Here are the numbers of pills she had left:

Phenobarbital	1579
Dexedrine	385
Benzedrine	347
Thyroid	191
Ammonium chloride ...	151

Hans Schroeder, M.D.
San Francisco, Calif.

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ancisco, Calif.



Dexedrine* Acknowledged to be the agent of choice

(1) for control of appetite in weight reduction

(2) as an antidepressant



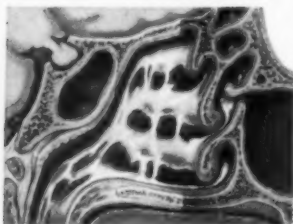
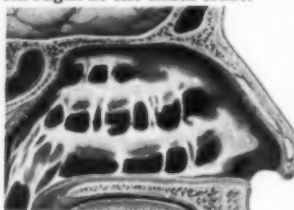
Tablets • Elixir • Spansule† capsules

Smith, Kline & French Laboratories, Philadelphia

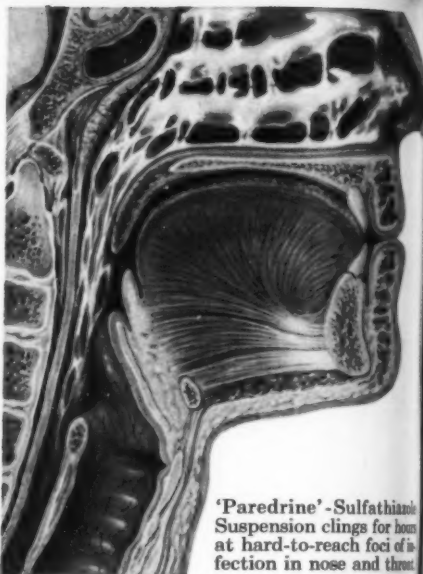
©1972 Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

(Reduced for S.K.F.'s brand of sustained release capsules (patent applied for).)

'Paredrine'-Sulfathiazole
Suspension spreads
throughout the nasal tract.



Suspension drifts over naso-
pharynx, coating inflamed areas.



'Paredrine'-Sulfathiazole
Suspension clings for hours
at hard-to-reach foci of in-
fection in nose and throat.

Instilled intranasally, 'Paredrine'-Sulfathiazole Suspension deposits a fine, even frosting of microcrystalline sulfathiazole throughout the nasal tract. Unlike solutions, this highly bacteriostatic coating does not quickly wash away, but remains for hours, clinging to the inflamed mucosa wherever ciliary activity is impaired by infection. *Bacteria in postnasal drip are neutralized before they can reach the nasopharynx and pharynx to intensify the infection.*

Moreover, part of the Suspension drifts down over the nasopharynx and pharynx, giving you the potent, prolonged bacteriostasis of microcrystalline sulfathiazole precisely where it is needed most, *at the site of infection in the throat.*

Paredrine*-Sulfathiazole Suspension

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide

Outstanding among Tar Preparations

- FOR CLINICAL EFFICACY
- FOR FREEDOM FROM REACTIONS
- FOR COSMETIC ELEGANCE

Tarbonis combines the three features needed for successful management of a host of dermatologic conditions:

It presents *all the therapeutic properties* of crude tar, but in a form liberated from the undesirable properties which so long have made tar therapy unacceptable to physician as well as patient.

It is so nonirritant, in spite of its dependable efficacy, that it is safely used for infants and on the tenderest body areas.

Tarbonis presents a specially processed liquor carbonis detergens (5 per cent), together with lanolin and menthol, in a vanishing-type cream base. It is greaseless, free from all tarry odor, and—since it leaves virtually no trace on proper application—is appreciated by the patient, especially when exposed body surfaces are involved.

TARBONIS is available through all pharmacies upon prescription. For dispensing purposes TARBONIS is packaged in 1-lb. and 6-lb. jars through Physicians' and Hospital Supply Houses.

In ECZEMA
INFANTILE
ECZEMA
PSORIASIS
FOLLICULITIS
SEBORRHEIC
DERMATITIS
INTERTRIGO
PITYRIASIS
DYSHIDROSIS
TINEA CRURIS
VARICOSE
ULCERS



Physicians are invited to send for clinical test samples to demonstrate the antipruritic, decongestant, remedial properties of Tarbonis in the conditions listed above.

THE TARBONIS COMPANY

4300 Euclid Avenue • Cleveland 3, Ohio

THE TARBONIS CO.

4300 Euclid Ave., Cleveland 3, Ohio

You may send me a sample of Tarbonis.

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ME-3

Liberated...
from the pain
and discomfort
of Chronic Arthritis



PABIRIN®

An effective clinical response, adequate to liberate the patient from the discomfort of chronic arthritis and rheumatic affections, can be achieved in a large percentage of patients with Pabirin. Thus many arthritics can be restored to useful activities.

PROLONGED, CONTINUOUS RELIEF

Pabirin produces higher salicylate blood levels because of the inhibitory effect of PABA on salicylate excretion. Hence, while the medication is taken, relief is prolonged and continuous.

SODIUM-FREE

All Pabirin is sodium-free. It can therefore be given with or between courses of ACTH or cortisone, and to hypertensives and cardiacs.


HIGHER POTENCY

Pabirin provides acetylsalicylic acid, widely regarded as the most efficacious and best tolerated of all salicylate compounds. In addition to 5 gr. each of aspirin and PABA, each capsule contains 50 mg. of ascorbic acid. Six capsules daily supply a full therapeutic dose of vitamin C to prevent excessive fall in the blood ascorbic acid level.

SMITH-DORSEY

Lincoln, Nebraska

A Division of THE WANDER COMPANY



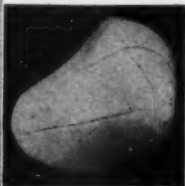
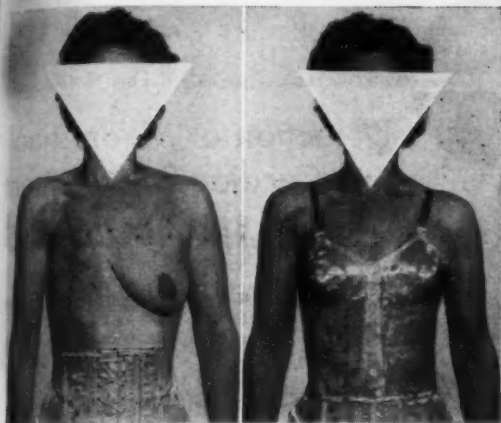
Each capsule now contains:

Acetylsalicylic acid.....	5 gr.
Para-aminobenzoic acid.....	5 gr.
Ascorbic acid.....	50 mg.

Pabirin is available at all pharmacies

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BOOTH 215
 Cleveland
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To lessen the fear of mutilation . . . order prosthesis before mastectomy

The psychological hazards of mastectomy are generally recognized. A woman's fear of mutilation—of its effect on her appearance—is often as great as her fear of surgery itself. That is why arranging for the correct prosthetic replacement *before* surgery helps to minimize the psychic trauma—enabling the patient to face the adjustment period with more calm and assurance.

The surgeon can prescribe Spencer Mastectomy Supports with complete confidence that they will meet both the medical and cosmetic indications. The reason: Each Spencer Breast Support and Breast Form is individually designed, cut and made for each patient.

Wherever support is indicated for breasts, back, abdomen—for women, men, children—you will find Spencer Supports demonstrably superior.

MAIL coupon at right—or PHONE
 a dealer in Spencer Supports
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 Therapy."

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individually designed supports

PEDIATRICS

Prepared in The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

BULLETIN

Detection of Mediastinal and Cardiac Enlargement

By X-RAY IN INFANTS

MANY CASES of unnecessary worry and concern result from faulty techniques in the X-Ray of chests of infants. The infant breathes rapidly, cannot hold his breath, and is often so uncooperative that it is not surprising that an X-Ray technician might fail to obtain a good film at full inspiration. The shape of the mediastinal mass and the heart in a film taken on expiration may be greatly distorted, particularly if there is even a little rotation.



● This affords an opportunity for the physician's self-education; to study a pair of films of a few healthy infants, one on full inspiration and one on expiration. The expiratory film may make the heart appear startlingly big and the mediastinum wide. To the unsophisticated, an inspiratory film following an expiratory film may give a completely satisfying picture of the effects of X-Ray therapy on the infant thymus.

● With the above in mind, the physician can beware of diagnosing a large heart or a mediastinal tumor in an infant—or a big thymus, if he is still interested in this ancient worry—on the basis of an X-Ray, unless skillfully taken and critically studied.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and appear monthly in Medical Economics.

OVER 50 VARIETIES—Strained Foods, Junior Foods, Pre-Cooked Cereals



Symbol Of Fine Quality Since 1869



Heinz Baby Foods And Heinz Baby Food Advertising Are Reviewed And Accepted By The Council On Foods And Nutrition.

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Baby Foods

You Know It's Good
Because It's Heinz

38.4 Hours

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14.8 Hours

Sulfadiazine

Repeated injections
penicillin

Mixed sulfonamides
and penicillin

Vollmer and co-workers¹ found that the combination of sulfonamides and penicillin reduced fever in their series of patients more rapidly than either sulfadiazine or penicillin alone.

COOPERATIVE ACTION IN CLINICAL MEDICINE

BICILLIN-SULFAS combines BICILLIN®—the new penicillin compound—and SULFOSE®—the superior triple sulfonamide. These work together to widen the antibacterial spectrum, to supply advantages not found with other penicillin-sulfonamide combinations.

BICILLIN is relatively insoluble penicillin. It therefore resists gastric acid, is free from penicillin bitterness, is absorbed uniformly.

SULFOSE—sulfa -diazine, -merazine and -methazine in aluminum hydroxide—gives high and prolonged sulfonamide blood levels with minimal possibility of crystalluria.

Available: Suspension, bottles 3 fl. oz. Tablets, bottles of 36. Each teaspoonful (5 cc.) of Suspension and each Tablet contains 150,000 units of BICILLIN and 0.5 Gm. triple sulfonamides.

BICILLIN®-SULFAS

diacetylmethoxybenzylpenicillin G and triple sulfonamides
J. Vollmer, H., et al.: New York State J. Med. 50:2293 (Oct.) 1950.

Wyeth

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Philadelphia 2, Pa.



EAST MEETS WEST...



THE NATIONAL DRUG COMPANY *Philadelphia 44, Pa.*



Purified alkaloids of two ancient medicinal plants—*RAUWOLFIA SERPENTINA*, from India, and *VERATRUM VIRIDE* (green hellebore; Indian poke) of the Western world—are now combined in *RAU-VERTIN* tablets for safer, smoother, sustained control of hypertension. *RAU-VERTIN* promptly produces a gradual, prolonged lowering of blood pressure, with remarkable freedom from side effects. Proper combination of these alkaloids potentiates their effects, permits smaller, safer doses. In fact, *RAU-VERTIN* therapy generally creates a pronounced sense of tranquillity and well-being. **AVERAGE DOSE:** 1 tablet, 3 times daily, after meals. Bottles of 60 and 250 tablets.

...to help the hypertensive

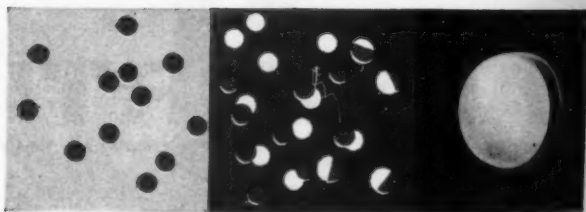


RAU-VERTIN

A COMBINATION OF SELECTED ALKALOIDS OF *RAUWOLFIA SERPENTINA* AND *VERATRUM VIRIDE*



iron plus calcium in one molecule



Each tablet contains iron, 25 mg., and calcium, 85 mg.
Adult dosage: two tablets t.i.d. with meals.

blec... a new compound
for iron-calcium
therapy...

...one uncoated, non-effervescent tablet
...gastrintestinal disturbances
...pending therapeutic response

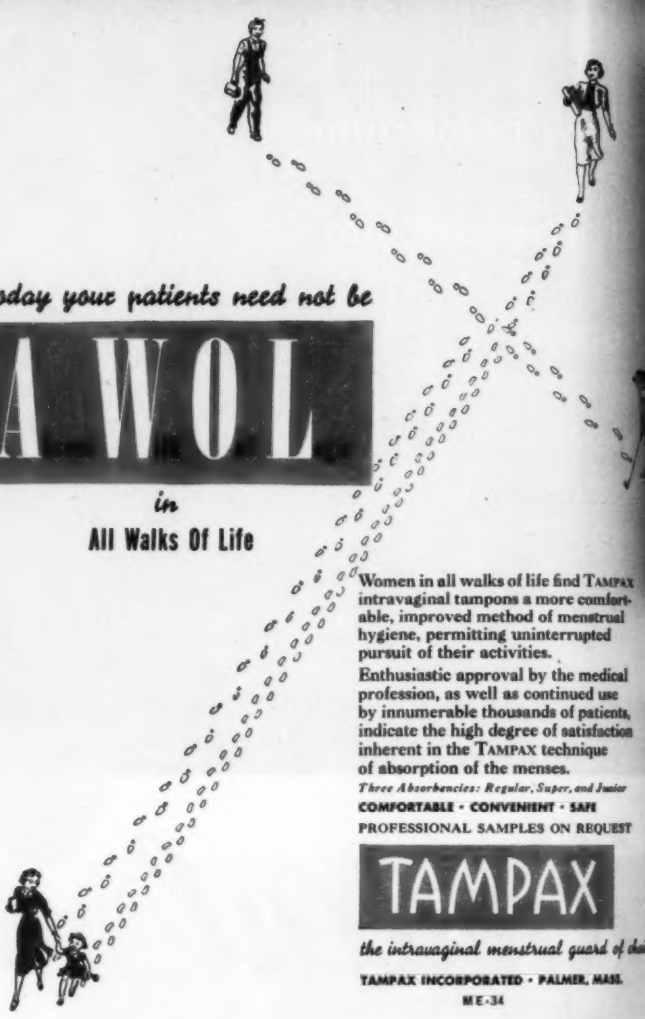


Rarical ^{T.M.}
TABLETS

ferrous calcium citrate
with tricalcium citrate

...cium, 85 mg.
...with meal.

Ortho Pharmaceutical Corporation, Raritan, New Jersey



Today your patients need not be

A W O L

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All Walks Of Life

Women in all walks of life find TAMPAX intravaginal tampons a more comfortable, improved method of menstrual hygiene, permitting uninterrupted pursuit of their activities.

Enthusiastic approval by the medical profession, as well as continued use by innumerable thousands of patients, indicate the high degree of satisfaction inherent in the TAMPAX technique of absorption of the menses.

Three Absorbencies: Regular, Super, and Junior
COMFORTABLE • CONVENIENT • SAFE
PROFESSIONAL SAMPLES ON REQUEST

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the intra vaginal menstrual guard of choice

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comfort-
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SOCIATION

Green light for asthma?

not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes...Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours...Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

Prompt and prolonged relief with Tedral can be initiated any time, day or night, whenever needed, without fear of incapacitating side effects.

Tedral provides:

theophylline	2 gr.
ephedrine	$\frac{3}{8}$ gr.
phenobarbital	$\frac{1}{8}$ gr.

in boxes of 24, 120 and 1000 tablets

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NEW YORK



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PEPTIC ULCER

patient with Donnalate



Antacid protection from hyperacidity

Demulcent protection from erosion and irritation

Spasmolytic protection from autonomic hypermotility

Sedative protection from psychogenic hypermotility

prompt
prolonged
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Remember... 2 tablets

DONNALATE

= 1 tablet DONNA tal
(spasmolytic-sedative)

+

2 tablets Roba LATE
(antacid-demulcent)

Hyoscyamine Sulfate	0.1038 mg.
Atropine Sulfate	0.0194 mg.
Hyoscine Hydrobromide	0.0066 mg.
Phenobarbital (1/4 gr.)	16.2 mg.

Dihydroxy aluminum aminoacetate 1 Gm.

A. H. ROBINS CO., INC.
RICHMOND 20, VIRGINIA

Questions

Restriction in partners'

agreement • Tax deductions for post-graduate study • Stock split • A.M.A. on Social Security • Which fire extinguisher?

Partners' Agreement

I'm taking the first step toward partnership with a young man from out of town. We both agree that if we don't make a go of our one-year trial arrangement, he won't stay and set up a separate practice in this area. Would such an agreement be considered ethical if we wrote it into our contract?

Nothing in the Principles of Medical Ethics would seem to prohibit the agreement you have in mind. In fact, such understandings are quite common—particularly when one of the partners is better established in the community than the other.

You'll do well to consider, though, whether your contract will be legally enforceable. The courts have generally upheld *reasonable* restrictions of this sort. But your attorney can best judge whether yours meets the two conditions usually imposed:

1. The restricted area should be well defined and within normal travel range. (In one case, the courts upheld an agreement that compelled the second partner to move at least 15 miles away; in another involving

a rural practice, a 100-mile restriction was deemed lawful.)

2. Fulfillment of such an agreement must not result in inadequate medical care for the public.

Deductions for Study

I remember reading in *MEDICAL ECONOMICS* that the cost of post-graduate courses is tax-deductible. But the Internal Revenue Service—at least the local office—tells me I can't deduct the cost (about \$4,000) of the full-time course in surgery that I recently completed. Are they right?

Yes, they are. But you're right, too—in remembering that the cost of *some* post-graduate study is deductible. A court decision last year (analyzed in *MEDICAL ECONOMICS* in July, 1953) set a new Federal policy on deductions for post-graduate work. Here's what that policy is:

You can deduct the cost of post-graduate study that helps you maintain the standards of your *present* practice. (For example, a refresher course in antibiotics would qualify.)

But you may not deduct for work

a *real* advance
in control of
rheumatic pain
and **spasm**



mephosal



relaxant mephenesin

"solubilized"*

and activated by

analgesic sodium salicylate

• **greater predictability**

• **greater safety**

IMPORTANT

— now 3 dosage forms for
greater flexibility and convenience



- (1) **MEPHOSAL CAPSULES** — Simple combination of mephenesin and sodium salicylate for broad-range, general rheumatic therapy.
- (2) **MEPHOSAL TABLETS** with HMB, and
- (3) **MEPHOSAL ELIXIR** with HMB — both containing homatropine methylbromide, for use in rheumatic cases associated with gastrointestinal disturbance.

samples and detailed literature on request.

*A research development (Patent Applied For) of



CROOKES LABORATORIES, INC.
MINEOLA, NEW YORK

Therapeutic Preparations for the Medical Profession

78

QUESTIONS

that prepares you for a new career. So the cost of your study of surgery is not deductible.

Stock Split

A corporation I've invested in has just split its common stock on a two-for-one basis. My broker tells me my dividend income is likely to increase as a result. Is he giving me the true story?

Your income from any common stock depends, obviously, on the fortunes of the company. Theoretically, the income isn't altered by a stock split. You get just half as much money from each of twice as many shares.

But a study made last year by the New York Stock Exchange showed that 59 per cent of the common stocks that had been split in 1951 paid larger cash dividends in 1952. (Only about 18 per cent paid less than they had before the split.) True, many stocks that hadn't been split also increased their dividends in that year; but the percentage was smaller. So chances are good that you may profit by the split.

Social Security

Why, exactly, does the A.M.A. oppose coverage of physicians under the Old Age and Survivors Insurance section of the Social Security Act?

In the association's own words: Because "(a) big pensions mean big government; (b) like socialized medicine, such coverage involves compulsion; (c) physicians do not

B-D

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syringes

fit in multiple ways...

- every plunger fits every barrel
- every tip fits every standard Luer needle
- every scale fits exacting therapeutic requirements
- every syringe fits professional demands for maximum durability, smooth operation, and accurate dosage

sizes now available:
2 cc., 5 cc. and 10 cc. — LUER-LOK[®] or Metal Luer tip.

BECTON, DICKINSON AND COMPANY, RUTHERFORD, N. J.

B-D, MULTIFIT and LUER-LOK, T M REG U S PAT OFF



QUESTIONS

retire young enough to take full advantage of the benefits promised for which they would prepay only a small part of the cost; and (d) pending legislation (H.R. 10 and 11) would provide a voluntary, individual retirement system for self-employed physicians as a counterpart of tax deferment privileges enjoyed by employees and officers under tax-exempt approved pension plans of corporations."

Fire Extinguisher

What's the most practical type of fire extinguisher for a one-man office?

Your best bet may well be a combination of extinguishers: one large

carbon dioxide unit and three or four of the small, inexpensive (\$1.50 each) carbon tetrachloride units—one for each room of your office. With these, you can nip incipient blazes on the spot and protect the office against larger fires.

Both CO₂ and carbon tet extinguishers have advantages over water-type units. They can be used effectively on all small fires, whereas water is definitely dangerous when used on chemical or electrical fires. The chemical units are clean, too. Unlike water, they leave little residual mess or damage.

You realize, of course, that the fumes from any carbon tet extinguisher are to be avoided because of their toxicity.

purified Corticotropin-gel wilson



THE ONLY COUNCIL
ACCEPTED ACTH GEL

More economical than ever!
New Price Reduction!

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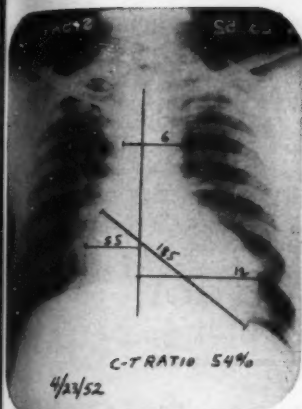
THE WILSON LABORATORIES

DEPARTMENT 1-6

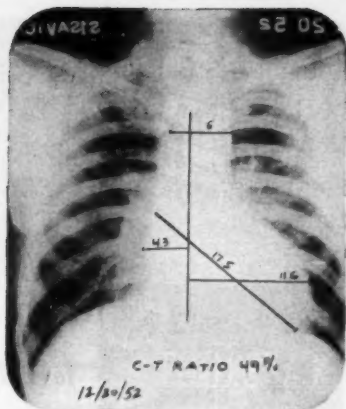
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and three or
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ectrical fires.
clean, too.
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Before P.S. before Methium: Cardio-thoracic ratio 54%, blood pressure 240/160 mm. Hg.¹



After Methium: Cardio-thoracic ratio 49%, blood pressure 160/100 mm. Hg. This patient (F.S.) experienced no toxic side effects and did not lose a single day of work.¹

Functional improvement from stabilized, lower blood pressure

In the first few months of therapy, over 80 per cent of the patients treated with oral hexamethonium have had gradual reduction in mean blood pressure of 20 mm. Hg or more.^{2,3} With continued treatment, up to or beyond a year, this reduction can often be maintained with no serious side effects and no increase in dosage.³

As blood pressure is reduced, and even without reduction, hypertension symptoms have regressed. Retinopathy may disappear, headache, cardiac failure and kidney function may improve.

Methium, a potent autonomic ganglionic blocking agent, reduces blood pressure by interrupting nerve impulses responsible for vasoconstriction. Because of its potency, careful use is required. Pre-treatment patient-evaluation should be thorough. Special care is needed in impaired renal function, coronary disease and existing or threatened cerebral vascular accidents.

1. Kuhn, P. H.: *Angiology* 4:195 (June) 1953.
2. Moyer, J. H.; Snyder, H. B.; Johnson, I.; Mills, L. C., and Miller, S. I.: *Am. J. M. Sc.* 225:379 (April) 1953.
3. Moyer, J. H.; Miller, S. I., and Ford, R. V.: *J.A.M.A.* 152:1121 (July 18) 1953.

Methium[®]

CHLORIDE

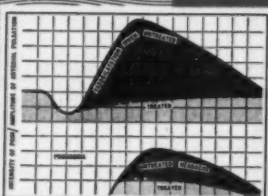
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WARNER-CHILCOTT
Laboratories NEW YORK

**VASCULAR
HEADACHES**
Reminder #1

CAFERGOT
TABLETS



EFFECT OF CAFERGOT ON COURSE OF ATTACK*

GYNERGEN-INJECTION 1451 *a guide to proper therapy*

INJECT: 1 cc. (0.5 mg.) i.m. Ergonovine
Tartrate (Gynergen N.N.R. 19)

RELIEF: indicates headache is vascular
(e.g., migraine).

*for relief of
subsequent migraine attacks*

Gynergen® has been shown to be *specific* in relieving
throbbing, recurrent head-pain typical of vascular
aches. The pain is due to dilatation of cranial arteries.

By reducing the amplitude of pulsations,
Gynergen interrupts the pain-causing mechanism.

Therefore, when the Gynergen-injection
is positive, Cafergot® tablets (Ergonovine
Tartrate 1 mg. and caffeine 100 mg.) are
effective and convenient treatment for subsequent attacks.

DOSAGE: 2 or 3 tablets by mouth at first
symptoms (either at prodroma or onset
head pain). Additional tablets as indicated
at ½ hour intervals (6 maximum).

Supplied: Bottles of 20 and 100 tablets.

(adapted from Wolff, H. G.: Headache and Other Head
Pain. Oxford University Press, New York, 1948, p. 268.)

Literature on Vascular Headaches, yours for the asking.

CAFERGOT S VASCULAR HEADACHE

Sandoz

PHARMACEUTICALS

DIVISION OF SANDOZ CHEMICAL, KENILWOOD, ILL.
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Cortef*
for inflammation,
neomycin
for infection:

Neo-Cortef

Acetate Ointment

TRADEMARK FOR THE UPJOHN BRAND OF HYDROCORTISONE (COMPOUND F) WITH NEOMYCIN SULFATE

Available in 5 Gm. and 20 Gm. tubes

Each gram contains:

Hydrocortisone Acetate . . . 10 mg.
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Neomycin sulfate 5 mg.
(equivalent to 3.5 mg. neomycin base)
Methylparaben 0.2 mg.
Butyl-p-hydroxybenzoate . . 1.8 mg.

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*My, these treatments are so
COMFORTABLE and QUICK!*



*That's just one of
the reasons why doctors
have bought over
17,000 MICROTHERM[®]
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our new bulletin, *The
Ultimate in Diathermy.*



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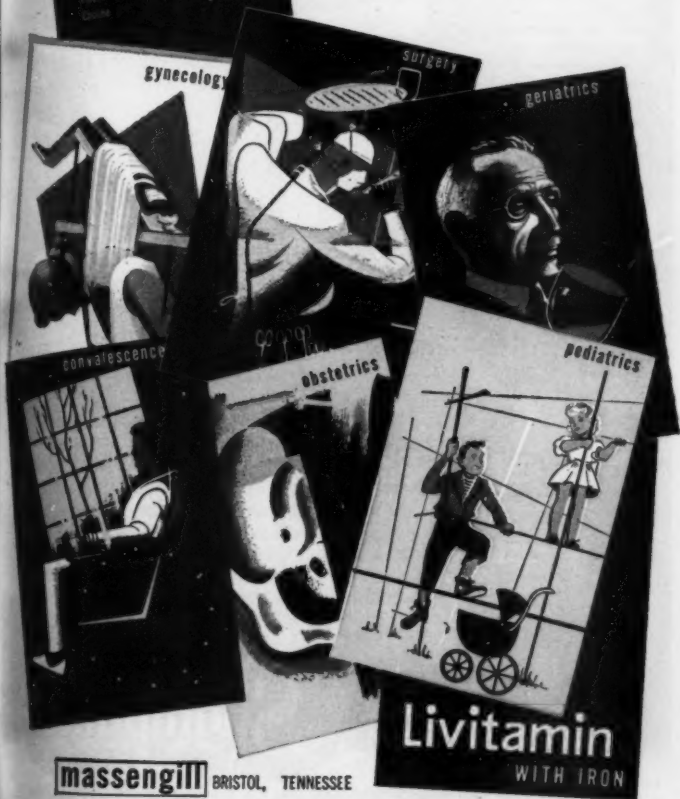
THE RECONSTRUCTIVE IRON TONIC..... of

of wide application

Provides the multiple requirements for effective treatment of nonspecific asthenia.

The combined therapy is designed to increase appetite and improve the blood picture. Better digestion and improved anabolism are part of the corrective process.

Livitamin is designed to treat the entire syndrome



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Livitamin
WITH IRON

IT'S I.D.* THAT DOES IT!

SHAMPAINE STEELUX GIVES YOU DISTINCTIVE BEAUTY AND CONVENIENCE

Recessed Pedestal
Base lets examiner
stand or sit closer
to patient.

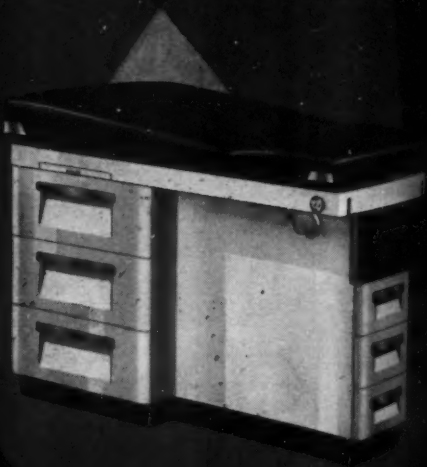
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Button Stirrups are
out of way until in
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Color coordination
for interiors of
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Properly contoured
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with acid-resistant
plastic.



Manufacturers of a Complete Line of
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Only in Shampaine Steelux do you get this original, beauty-inspired, ultra-functional styling. Only Shampaine's * "Integrated Design" provides you with features and accessories "built in" as an integral part of the equipment... and room groupings coordinated in design and a wide choice of colors. Only Shampaine Steelux with "I.D." gives you full color beauty combined with functional convenience. See your dealer.

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every child is at the Stride Rite Age

From the first walking year to the teens
... there's a Stride Rite style, size and width
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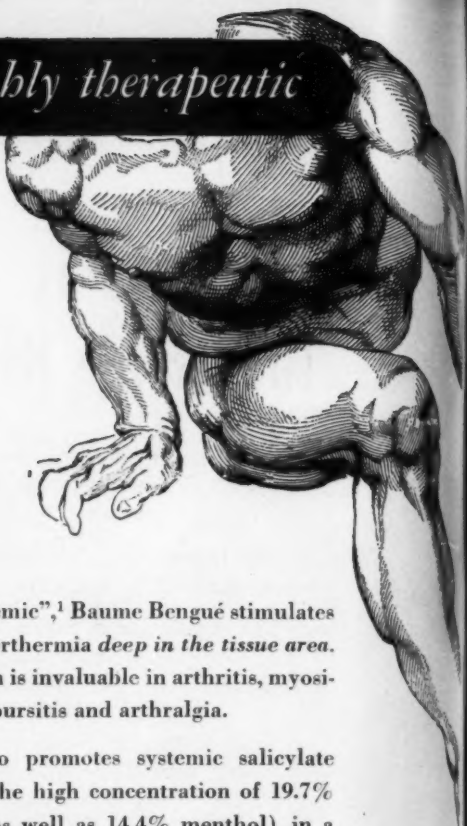
What is more important ... there's a Stride Rite
shoe that will *fit* every pair of young feet.

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on outstanding quality, skilled workmanship
... and above all, on exacting fit. And
not only are Stride Rites *made* to fit
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STRIDE RITE
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DOCTOR: If you are not already familiar
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thoroughly therapeutic



As a true "hyperkinemic",¹ Baume Bengué stimulates hyperemia and hyperthermia *deep in the tissue area*. This thorough action is invaluable in arthritis, myositis, muscle sprains, bursitis and arthralgia.

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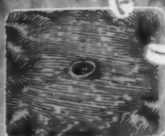
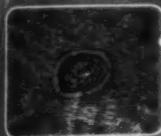
I. Lange, K., and Weiner, D.: J.
Invest. Dermat. 12:263 (May) 1949.

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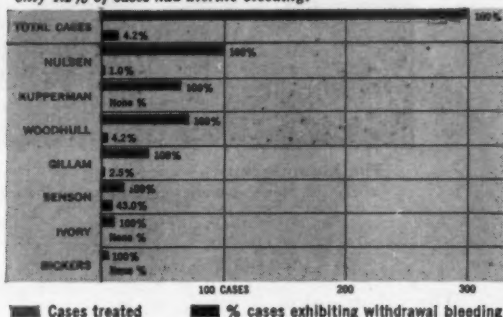
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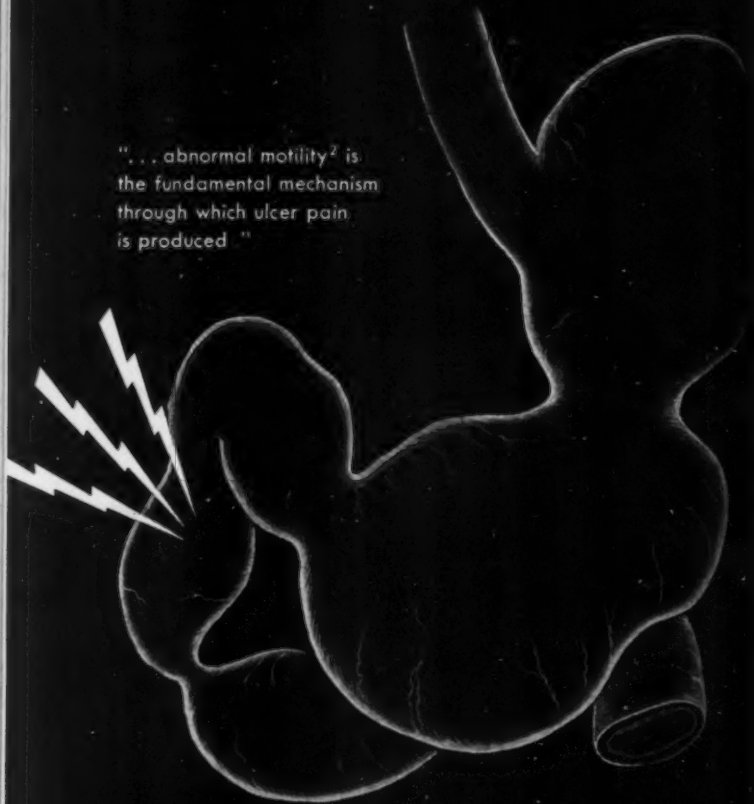
Cobalt.....	0.1 mg.
Copper.....	1 mg.
Iodine.....	0.15 mg.
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Manganese.....	0.33 mg.
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Abnormal Motility

"... abnormal motility² is
the fundamental mechanism
through which ulcer pain
is produced "



Motility is the Cause of Ulcer Pain

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Abnormal motility in addition to acid appears to be chief cause of ulcer pain.

Until recently the general opinion was held that ulcer pain was primarily caused by the presence of hydrochloric acid on the surface of the ulcer.

Present investigations^{1,2} on the relationship of acidity and muscular activity to ulcer pain have led to the following concept of its etiologic factor:

"... abnormal motility² is the fundamental mechanism through which ulcer pain is produced. For the production and perception of ulcer pain there must be, one, a stimulus, HCl or others less well understood; two, an intact motor nerve supply to the stomach and duodenum; three, altered gastroduodenal motility; and four, an intact sensory pathway to the cerebral cortex."

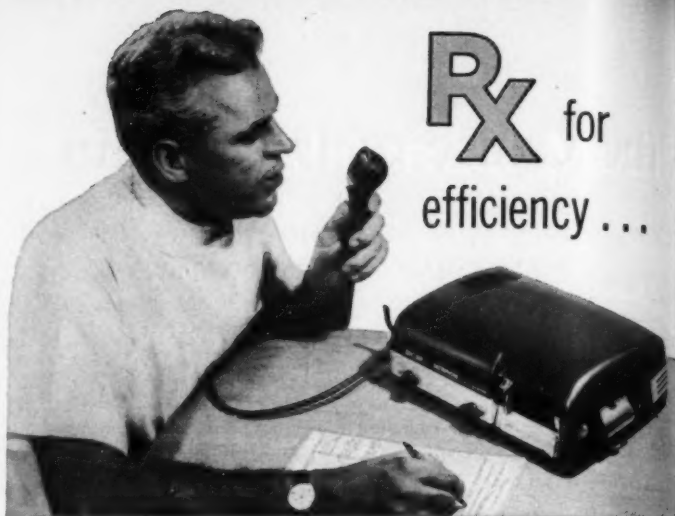
Pro-Banthine has been demonstrated consistently to reduce hypermotility of the stomach and intestinal tract and in most instances also to reduce gastric acidity. Dramatic re-

missions¹ in peptic ulcer have followed Pro-Banthine therapy. These remissions (or possible cures) were established not only on the basis of the disappearance of pain and increased subjective well-being but also on roentgenologic evidence.

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1. Schwartz, I. R.: Personal Communication, Feb. 9, 1953.

2. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, *Gastroenterology* 23:252 (Feb.) 1953.



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Medical Economics

MARCH 1954 • VOLUME 31 • NUMBER 6

Editorial:

'We're Ag'in' It. But . . .'

● In the field of Governmental policy, physicians are sometimes accused of being *against* everything. But, according to Roger Fleming, secretary-treasurer of the American Farm Bureau Federation, we needn't worry about it too much.

At the last A.M.A. P.R. Conference, Mr. Fleming spoke of an observation he had made during a trip through the apple-raising section of the Shenandoah Valley in Virginia:

Farmers there spend a lot of time and money applying sprays to kill coddling moths. Because they do that, some people think they are *against* the coddling moth.

Not at all, said Mr. Fleming. They simply *like* apples.

* * *

Roger Fleming's story is a good one. But, unfortunately, medicine *does* have to worry about the charge of being *against* everything.

Witness these paragraphs from a letter a colleague of ours wrote us the other day:

"I'm no left-winger. Generally, I agree pretty fully with the political position taken by the A.M.A.

"But it makes me squirm—and I do mean squirm—every time the Administration in Washington says, 'Here's what we think ought to be done to improve medical care,' and the A.M.A. instantly cries, 'Nothing doing! We don't want any part of it.'"

One of the profession's key problems, as this reader appreciates, is: How can we oppose the many unsound schemes put forward for medicine without seeming always to be destructive instead of constructive?

[MORE→]

In other words: How can we do what we must, yet avoid having the medical profession typed by the public as a homogeneous bunch of backward-looking reactionaries?

First off, let's agree that a lot of poor ideas for improving health are promoted these days and that the profession must oppose them.

But let's realize also that while we have to make some negative statements, we can also make some positive statements. In fact, the many *good* ideas we have developed merit more comment than they've been given.

Suppose that every time medicine made a public statement *against* something it opposes, it also made two statements *for* things it favors. Wouldn't the two positives do a lot to overcome the one negative? Wouldn't they, at any rate, be an improvement over the no-no-no talk that so often rubs the public the wrong way?

Blood Banking Blowup

The Hatfields and the McCoys had nothing on organized medicine and the Red Cross in their current feud over blood banks.

While it's true that leaders on both sides have been working hard to bring harmony out of discord—and have succeeded in a number of places—blood banking the country over is still in a state of unholy turmoil.

Rank-and-file physicians, inter-

viewed for an article in this issue, say that both sides are to blame. The Red Cross, they charge, is more concerned with blood as a fund-raising gimmick than as a therapeutic commodity. Organized medicine, they add, is likewise at fault for having failed to concern itself with blood banking until the Red Cross was firmly established in that field.

We think there's a good deal of truth to these charges. And we think that similar charges could be applied to the relationship between organized medicine and many other lay health organizations.

In the trail of the associations set up to combat TB, polio, cancer, and heart disease has come an almost endless procession of others. The ones with the most competent fund-raising staffs are the ones that get the most support. The correlation between the amount of money raised and the importance of the disease attacked is often hard to find.

Whether medicine's leaders recognize it or not, the time has come for the profession to take a lot more active interest in what the lay health organizations are doing and planning. One of the many constructive projects organized medicine could well undertake in behalf of John Q. Public (including John Q. Physician) would be to make, and publicize, a careful analysis of these lay health agencies, showing what relative financial support each one merits, and why.

—H. SHERIDAN BAKETEL, M.D.

Relatives on Your Payroll

Their salaries are tax-deductible only if their employment is 'reasonable.' This article explains when it is and isn't—with case histories

By Ralph R. Benson, LL.B.

● It's not illegal to like your relatives. Nor is it illegal to put them on your payroll. Members of your family may well be the most loyal and competent employees you could find.

But will the salaries you pay them be allowed as business expenses on your Federal income tax return? That's up to you.

When an Internal Revenue agent questions the deductibility of a salary paid to a relative, it's generally because:

1. The salary is out of line with the local prevailing scale; or
2. He doubts that the work was necessary, or even that it was performed.

The moral is self-evident. *Justifiable* and *reasonable* salaries paid to members of your family are fully tax-deductible, like other business expenses.

Unfortunately, it isn't easy to know what will be considered justifiable and reasonable in all circumstances. So, from my own experience and from Federal court and departmental records, I've collected sample cases covering most of the questions likely to arise: [MORE→]

RALPH R. BENSON is a Los Angeles attorney specializing in medicolegal matters. He is also a former lecturer on business law, for C.P.A.s, at the University of California, and a co-author of the Commerce Clearing House Federal Tax Course.



The Doctor's Uncle

1. Doctor A's uncle has retired after working in a shirt factory most of his life. He needs a bit more income than his pension allows, so the doctor hires him to collect his overdue bills. He gives the old man \$25 a week, plus 25 per cent of all accounts collected, plus travel expenses.

QUESTION: *Can Doctor A deduct from his income tax the salary, commissions, and expenses paid his uncle?*

ANSWER: Yes, they're deductible in full. The rates, as set, are quite reasonable, considering that many collection agencies charge commissions as high as 50 per cent. And the amounts paid are undoubtedly in return for services actually rendered, because all compensation above a modest minimum is based on an incentive plan.



The Retired Father

2. Doctor B has been supporting his 70-year-old father, a retired carpenter, by giving him \$4,800 a year. Since the doctor can claim only a \$600 dependency exemption on his tax return, this means that he gets no tax relief on \$4,200 of the amount he pays out annually.

He decides to change this by putting his father on the payroll as an accountant, at the same \$400 a month—even though he's already paying a C.P.A. \$75 a month to look after his books. The father is of no help either to the C.P.A. or to Doctor B's secretary in keeping the records.

QUESTION: *Will the Internal Revenue Service allow the father's salary, or any part of it, as a tax deduction?*

ANSWER: Definitely no. In fact, since the value of the father's "serv-

ices" is obviously zero, any attempt to claim the yearly \$4,800 as a professional deduction may well be judged an evasion of taxes, calling for severe penalties.

it's for services actually rendered. The dependency exemption is also allowable because the son earns less than \$600 a year and receives more than half his support from his father.



A Son's Allowance

3. Doctor C's 14-year-old son has been receiving a \$4 weekly allowance. The doctor decides he can cut his taxes by employing the boy as a messenger between his office, the laboratory, and the radiologist. The boy thereafter works one hour a day, four days a week, and gets the same \$4, but this time as a salary.

QUESTION: *Is the boy's salary deductible on Doctor C's tax return? And if the doctor deducts it, can he also claim the full \$600 dependency exemption for his son?*

ANSWER: Yes, on both counts. The salary paid is reasonable and



Medical-Student Cousin

4. Doctor D sends his cousin to medical school for a year, paying the tuition directly and giving the cousin \$200 a month to live on. For this the doctor gets no tax benefit, because cousins may not be listed as dependency exemptions.

So the next year the doctor decides to employ his student-cousin as part-time business manager and medical assistant at \$500 a month, although he has never hired anyone in either capacity before.

QUESTION: *Can he deduct the \$500 a month as a professional expense?*

[MORE→]

RELATIVES ON YOUR PAYROLL

ANSWER: Yes—as long as he's able to show that he had to hire *someone* with the same qualifications as his cousin for the same work at the same hours and salary. The key requirements of *reasonable payment* and *services actually rendered* are thus met.

This case underlines the difference between tax *avoidance* and tax *evasion*, and affirms the doctor's right to choose any legitimate method to reduce his taxes.



Mother-in-Law's Pay

5. Doctor E pays his mother-in-law \$5 an hour to act as his receptionist every day from 12 to 2, while the regular girl is at lunch. The regular receptionist gets \$1.25 an hour and a former one was paid \$2 an hour. The prevailing rate for such service locally is \$1.50 an hour.

QUESTION: *How much of the \$5 rate can the doctor deduct as a legitimate expense?*

ANSWER: No more than the prevailing \$1.50 an hour. Doctor E may expect no tax benefit from the additional \$3.50 paid his mother-in-law unless he can show that exceptional circumstances warranted it.

The fact that the regular receptionist is paid less than the prevailing rate—and that a former one was paid more—is immaterial. Each employee's wage must stand on its own merits as to reasonableness.



Father as Advisor

6. Doctor F's father, a retired physician, often counsels his son on matters relating to the son's practice. So Doctor F puts his father on the office payroll at \$100 a week for his advisory services.

QUESTION: *Is Doctor F justified in deducting such payments, or any part of them, as business expenses?*

ANSWER: Doctor F runs the risk of having the entire \$100 a week disallowed. True, it can probably be shown that actual services are rendered by the father. But it may well be argued that these services have only nominal value and do not merit a price tag.



Son's Bonus Check

7. Doctor G employs his son, also a physician, for three months at \$700 a month. The salary is reasonable in view of the services required. When the son leaves to set up practice in another city, the father gives him a \$500 bonus. It has the appearance of severance pay, but it is actually to help the son furnish his new office.

QUESTION: *Is the \$500 bonus a tax-deductible item for Doctor G?*

ANSWER: No. Bonuses or severance pay are deductible when made "in good faith"—that is, if, together with sums already paid, they don't amount to "unreasonable" compensation for work done. But in this case, the \$500, given after only three months' employment, appears to be more an expression of a father's generosity than a "reasonable" transaction between two doctors.



Wife as Receptionist

8. Doctor H puts his wife on his payroll as a receptionist, at \$2,500 a year, to qualify her as an employee for Social Security benefits.

QUESTION: *Is Mrs. H entitled to Social Security benefits under this arrangement? And can Doctor H save taxes on his \$15,000 net income*

by deducting the salary paid her?

ANSWER: No. Under the present law, certain relative-employees of doctors—including wives, minor children, and parents—are excluded from Social Security coverage. Doctor H is allowed to make no payroll deductions from his wife's salary and to contribute nothing to the Government on her account.

Nor does his wife's employment lessen Doctor H's taxes, even though her salary is tax-deductible. On the joint tax return they file, their combined incomes are still the same as the doctor's income would have been otherwise. To illustrate:

Whether the doctor has a net income of \$15,000 and his wife has none, or whether the doctor has a net of \$12,500 and his wife has \$2,500, makes no difference. The tax is the same.

In the cases enumerated, we've been concerned only with the salary deductions allowed (or disallowed) the doctor-employer on his return. But how about the employe-relative?

Where wages paid him are not deductible by the doctor, may the relative consider them as a gift, and leave them out of his return?

The Government's answer here is again no. A relative's full income must be reported and tax paid on every penny of it. Regardless of an employer's inability to deduct a certain salary, it is still a salary, not a gift, to the employe and must be so reported.

END

He Takes the Pulse Of Congress

By Edwin N. Perrin

● George W. Calver is probably the only man in the world who can order any U.S. Senator to hop ten times on one foot, then ten times on the other—and be obeyed.

For Dr. Calver is the official physician of Congress. His patients, headed by Vice President Nixon, consist chiefly of Senators, Representatives, and Supreme Court justices.

[MORE→]



A WELL-KNOWN FIGURE in Washington himself, George Calver pauses at the statue of a notable American physician, to chat with a Senate page boy.

A graying man of 66, Dr. Calver has held his job through thirteen Congresses—ever since 1928, when President Hoover took office. But, unlike Hoover, he stepped into a newly made position: He's the first Congressional doctor in history.

It was only a quarter century ago that Congress got around to voting itself free medical care. Then it asked the Navy Department to submit a list of eligible physicians for the job. Why the Navy? Apparently because most U.S. Presidents since Theodore Roosevelt had picked their personal physicians from that service (a tradition not followed by General Eisenhower).

The most eligible candidate turned out to be 40-year-old George Calver. His record showed that he'd been born in Washington, was the son of a doctor, and had received his M.D. from George Washington University in 1912. Soon afterward, he had entered the Navy; and in the next fifteen years he had served half-way around the world—from the Potomac to the Yangtze and back.

He Likes People

But what perhaps most impressed the Congressmen, apart from Dr. Calver's solid medical background, was the warmth of his personality. Like the legislators themselves, he has the knack of getting along with people. He likes them, and they like him. The walls of his office are lined with autographed pictures of his famous patients.

"It's typical of the man," says one Senator, "that he is not only Rear Admiral Calver, U.S.N., but also an 'admiral' in the Great Navy of the State of Nebraska."

And it's even more typical, the Senator adds, that some members of Congress don't realize that he's an admiral at all. Which may be just as well, since, despite his Navy rank, Dr. Calver's job is essentially a civilian one.

Heavy Work Load

He himself describes it as "health management" of the Congress; and theoretically the work is mainly preventive—keeping health records, giving check-ups, etc. But he also treats most members of Congress and the Supreme Court, their aides and employees, and all visitors to the Capitol who fall ill while there (as many as forty a day during the hot summer months).

To handle this load, Dr. Calver has the help of another doctor (a lieutenant commander in the Navy) and an all-male staff of Navy pharmacists and secretaries. In addition, his office runs six first-aid stations, one in each of the Capitol's six buildings.

His Routine

On a typical day, the doctor leaves his Washington home a little after 8 A.M. and drives to the naval hospital in near-by Bethesda, Md. There he takes 9 o'clock sick call and then drops into his [MORE ON 240]

Choosing a Location: How to Judge a Community

With the accompanying checklists as a guide, you can rate the significant characteristics of a town—and thus cut your risk of making a poor choice

By Don Cameron



● George Adamson, a Michigan G.P., is one of many doctors who picked wrong locations in the United States last year. With a background of thirty years of rural practice, he moved from one small town to another, slightly larger, in his home state—and he now wishes he hadn't. His name is changed here, but not his account of how he came to make such an unfortunate choice:

"A traveling salesman told me that the larger town was lively, prosperous, and had a great future—but no doctor. So I drove there and called on the local druggist, who said the salesman was right. Next I talked with a real estate agent, and he enthusiastically agreed. So did a man who ran a filling station, as well as a couple of other people.

[MORE→]

*This article is the fourth of several on the subject. Earlier ones have covered the basic factors in choosing a location, sources of leads, and the changing economics of the various regions and states. Factors that affect the choice of an office site will be discussed later. Material for the series has been drawn from many sources—among them the A.M.A. Physicians Placement Service, the directors of state and local placement programs, and a survey by MEDICAL ECONOMICS of the personal experiences of several hundred doctors who have relocated within the last year or two.

CHOOSING A LOCATION

"Since I'd been barely keeping my chin above water, that was all the encouragement I needed. I moved as soon as I could.

"What I learned *after* I moved was something else. Except for a brief summer tourist season, the larger town was far worse, economically and otherwise, than the place I'd left. Now I'm looking for a new spot—much more carefully."

When Dr. Adamson picks his next town, he vows, he'll be armed with a healthy skepticism developed the hard way:

"I'll expect the local pharmacist to encourage me, because a new doctor means more business for him. I'll expect the local M.D.s, if any, to be unenthusiastic, because they won't know me and some of them may not relish competition. I'll expect the people on the street to tell me how badly another doctor is needed, because most doctors appear overworked even when they aren't.

"So the information I'll finally act on is the kind I'll dig up for myself, see with my own eyes, and filter through my own mind. I've learned that, no matter how honest the other fellow tries to be, his view of the town won't necessarily be mine."

'Say-So for Gospel'

In questioning some hundreds of physicians after they had tried out new practice locations in 1952 and 1953, MEDICAL ECONOMICS found that more than 40 per cent were al-

ready dissatisfied. And most of the sorry ones mentioned experiences like Dr. Adamson's.

Not all of them had been so casual about their advance scouting. Some had tried hard to see what they were getting into, but had failed because of not knowing exactly what to look for or where to look for it. Others had taken say-no for gospel, without bothering to verify important points.

And a few had blindly succumbed to off-trail attractions—like the young M.D. who admitted he'd been sold on an Idaho town as soon as the mayor treated him to some first-class trout fishing. ("There were plenty of fish," he now says, "but damn few patients.")

Sizing Up a Town

The final test of *any* community, of course, is living and working in it. But there are, in lieu of that, some good rules to follow that will lessen your chances of going astray.

Make sure, for example, the location you select provides:

1. A social and cultural environment within which you and your family can live comfortable, rewarding lives;
2. An economy that assures the community's continued prosperity;
3. Professional opportunities that will help you practice medicine to the best advantage of your patients and yourself.

A check-list for each of these is included with this article. The en-

tent to which you can rate the various probabilities as good should determine your over-all chances for success and well-being in a particular community.

Chances are you'll already have some basic facts about the place—particularly if you've sought information from either the A.M.A. Physicians Placement Service or the placement program of the state in which you're interested. But the facts you *don't* have must come through your own observation and inquiry.

You'll probably find some drawbacks in every community you examine. The perfect location just doesn't exist. So the best you can expect is a reasonable compromise.

To make good use of the check-lists, you'll want to ask certain specific questions—both of yourself and others. So let's analyze the lists in some detail:

Living Conditions

Under the heading "Living Conditions" (Check-List No. 1) you can assess the social and cultural aspects

Check-List No. 1

Living Conditions

	Community A			Community B		
	Good	Fair	Poor	Good	Fair	Poor
1. The neighbors						
2. Appearance of homes, lawns, etc.						
3. Schools						
4. Churches and recreational centers						
5. Shopping facilities						
6. Transportation						
7. Police, fire, and other services						
8. Protective zoning measures						

CHOOSING A LOCATION

of a town or neighborhood. And the following questions—numbered to correspond with the eight subheads—should bring out most of the necessary facts:

1. Are your prospective neighbors fairly near your own social status? Are they likely to share your tastes and interests? (Talk with some of them. You'll soon know the answers.)

2. Are their homes neat and in good repair, with well-tended lawns and gardens?

3. Are there good schools within half a mile or so of where you'd live? Are they situated away from traffic and other hazards? (See them yourself—at least from the outside—and

question some of the local parents.)

4. Are churches, a library, and places of amusement and recreation available within a couple of miles?

5. Is there a neighborhood shopping center, and is there a major shopping area within easy reach by car or bus?

6. Does a local bus or car line pass near your prospective home?

7. Are police and fire protection, garbage collection, street maintenance, and other public services adequate? (If you want to be sure, ask private citizens and businessmen as well as city officials.)

8. Is the neighborhood zoned to exclude factories, railroad tracks, cemeteries, and cheap dwelling

Check-List No. 2

The Economic Picture

	Community A			Community B		
	Good	Fair	Poor	Good	Fair	Poor
1. Trend of community growth						
2. Diversification of economy						
3. Standard of living						
4. Attitude of business community						
5. Trend of property values						
6. The tax situation						

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units? (The neighbors *should* know. And real estate men and the town or city clerk will have all the details.)

These aren't by any means *all* possible questions; you'll undoubtedly think of others. But a neighborhood or community that stands up fairly well on the above points will probably pass muster otherwise as a livable place.

The Economic Picture

When you come to evaluate the economic health of a community (Check-List No. 2), you'll want specific information from business, industrial, and civic leaders. The people who can best answer your ques-

tions—and who'll usually be glad to—are bankers, the secretary or manager of the chamber of commerce, and municipal officials.

Your economic survey will cover the community as a whole, of course, whatever its size. And you can avoid the risk of getting biased information by asking for the *facts and figures* about such questions as the following:

1. Is the community growing, with the younger people staying put and more younger people moving in? Has the pattern of growth been consistent over a period of time, rather than in the nature of a temporary boom?

2. Does the community enjoy a

Check-List No. 3

Professional Factors

Community B

Fair Poor

Community A

Community B

	Community A			Community B		
	Good	Fair	Poor	Good	Fair	Poor
1. Doctor-population ratio						
2. Colleagues' attitude						
3. Hospital and other facilities						
4. Post-graduate education opportunities						
5. Prepaid health insurance coverage						
6. Prospects of early income aids						

diversified economy (not overly dependent on a single industry, or on a few industries subject to seasonable slumps)?

3. Are the standard of living and the per capita income as high as, or higher than, the average for the region? What proportion of the people are home owners, for instance; and how does this compare with the average elsewhere?

4. Does the business community actively support organizations, like the chamber of commerce, that work toward the economic development of the area?

5. Have business and residential property values increased in the last five years at a rate comparable with that of near-by communities—with-out as yet having reached their potential peak?

6. Are taxes and property assessments at what seems a reasonable level?

Expert opinions can be of great value in helping to interpret the facts and statistics you gather. But be sure they're *impartial* opinions, and not merely the optimistic assertions of civic boosters.

Professional Factors

In judging the possible future of a new practice in any community (Check-List No. 3), you ought to be able to get guidance from the county medical society. But if other physicians are practicing in the same locale, you'll find it both diplomatic and rewarding to call on them, too.

Here are the principal questions you'll want answered:

1. Does the population seem to be large enough to support every active practicing doctor, including you?*

2. Are your colleagues in the vicinity prepared to give you a cordial welcome and to offer the cooperation you'd need?

3. Are hospital and laboratory facilities available? Is it reasonably certain that you'd be able to get hospital privileges soon?

4. Is there a convenient medical center, where you would have the opportunity to continue your post-graduate education?

5. Does the area have widespread coverage by Blue Cross and Blue Shield or other health insurance plans?

6. As a new doctor with a practice to build, would you be able to earn fees at the outset by such activities as making examinations for the health department, board of education, or insurance and industrial firms?

Some Final Tips

Out of the experiences of many doctors in many [MORE ON 264]

*Estimates of minimum populations needed to support physicians vary according to living standards and other factors. Generally, 1,000 to 1,200 people are believed necessary for a G.P.; but many G.P.s do well with less. Some recent minimum population estimates for certain specialists: 15,000 for an obstetrician, anesthesiologist, or radiologist; 20,000 for a proctologist, allergist, or pediatrician; 30,000 for a psychiatrist or pathologist. Here again, however, there are no hard and fast rules.

Medical Costs in the U.S.

Door-to-door questioning of 3,000 American families has produced this first comprehensive picture in twenty years of how the nation buys, uses, and pays for health services

By Mauri Edwards

● Americans now run up a health bill of \$10.2 billion a year. This figure includes \$3.8 billion worth of physicians' services.

Various forms of voluntary health insurance pay for 15 per cent of the total. Individuals dig into their pockets for most of the rest—and so go into debt to the tune of \$1.1 billion a year.

These are a few highlights from the Health Information Foundation* survey of America's current medical bill. To collect the staggering array of statistics that make up the full report, surveyors interviewed members of nearly 3,000 families, numbering almost 9,000 individuals. The resultant information, covering America's health economics in fiscal 1953, adds up to the first such study of any magnitude since the early 1930s.

As such, it's a rich vein of information for the average medical practitioner. It may help him to understand better the economics of his patients' health. And it will certainly cast new light on the tumultuous changes that have

*The foundation was set up four years ago by a group of the nation's leading drug and chemical manufacturers as a nonprofit, impartial, fact-finding organization. The actual work of studying America's health costs was conducted for the foundation by the National Opinion Research Center of the University of Chicago during July, 1953.

MEDICAL COSTS IN THE U.S.

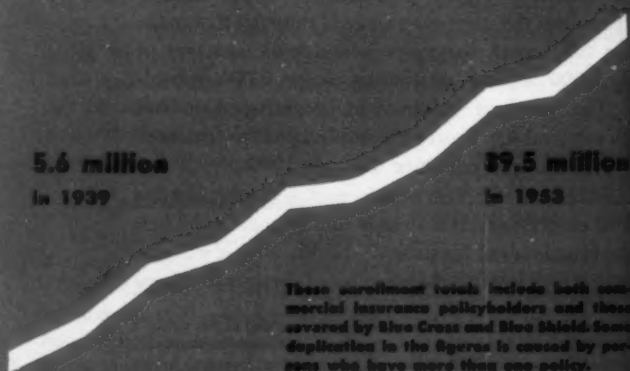
been—and are being—made in the economics of his own practice.

Through its survey, the Health Information Foundation sought answers to four questions:

1. How widely has voluntary health insurance spread?
2. What are the health costs of the average U.S. family?
3. How does the family use available health services?
4. To what extent does it go into debt to pay its health bill?

On the pages that follow are the main findings.

Growth of Voluntary Health Insurance



How Widely Has Health Insurance Spread?

► "Phenomenal" is the Health Insurance Foundation's word for the expansion of voluntary health insurance. And it backs up the word with figures:

In 1940, just 9 per cent of the people had hospital-care insurance. Today, 57 per cent are covered (half by Blue Cross, half by commercial plans).

And while only 4 per cent had surgical-care insurance fourteen years ago, 48 per cent have some such coverage now. Most of them

carry commercial, rather than Blue Shield, policies.

In all, says the foundation, 89.5 million Americans (58 per cent of the population) now enjoy some form of health insurance protection.

Despite these impressive growth figures, the H.I.F. study pinpoints some important weaknesses in present coverage:

¶ Although 80 per cent of families with annual incomes of \$5,000 or more have at least some health insurance, only 41 per cent of families in the below-\$3,000 bracket carry it.

¶ Barely 45 per cent of farm families are policyholders, contrasted with 70 per cent of urban families.

¶ The self-employed tend not to buy such coverage; less than half of them have it.

The failure of rural and self-employed persons to buy health insurance is explained partly by the fact that they're generally ineligible for group coverage (group insurance policyholders account for some 80 per cent of the total). So it's necessary, says the foundation, "to devise means whereby people without a common employer . . . can be grouped." Only then can they be enrolled "with as low an acquisition cost, as few limitations in benefits, and at the same premiums" as groups with a common employer. [MORE→



MEDICAL COSTS IN THE U.S.

Who Has Health Insurance

(By Type of Locality)

Urban	70%
Rural, non-farm	57
Rural, farm	45

Percentages represent families that have some voluntary health insurance.



Who Has Health Insurance

(By Occupation)

Craftsmen	83%
Clerical workers	80
Laborers	70
Professional men	65
Household workers	56
Business owners	54
Farm owners	35
Farm workers	34
All occupations	63

Percentages represent families that have some voluntary health insurance. Occupation listed is that of chief breadwinner.

Who Has Health Insurance

(By Income)

Under \$3,000	41%
\$3,000-\$4,999	71
\$5,000 and over	80

Percentages represent families
that have some voluntary
health insurance.

How Much Does Health Service Cost?

► More than a third of the nation's \$10.2 billion health bill consists of physicians' fees—\$3.8 billion in all. Of this total, surgery accounts for \$800 million and obstetrics for \$400 million.

Additional major costs, revealed by the Health Information Foundation study, are as follows:

Hospitals	\$2 billion
Dentists	1.6 billion
Medicines	1.5 billion
Other*	1.3 billion

But these are astronomical figures. Let's examine some of them in terms of average families, of everyday patients. Here's the picture as the H.I.F. draws it:

The average family runs up a health bill of \$205 a year. Out-of-pocket charges (which omit various insurance benefits) average \$178,

*This catch-all item includes outlays for such goods as medical appliances and for the services of such persons as private-duty nurses, optometrists, chiropodists, chiropractors, etc.

MEDICAL COSTS IN THE U.S.

broken down as follows: \$67 for physicians; \$21 for hospitals; \$31 for medicines; \$33 for dentists; and \$26 for other goods and services.

Looking at family health costs in another way, the median is \$110. In other words, half of America's families spend less than \$110 for health, and half spend more.

Among the families spending more than \$110 on health are 3.5 million that spend over \$495. Some

500,000 of these spend in excess of \$995.

Of course, a big health bill is not, in itself, evidence of catastrophe, says the foundation. More significant is the *proportion* of income spent. From this point of view, the survey shows that half the nation's families have health bills totaling no more than 4.1 per cent of their annual incomes.

But of those whose bills are great-

What Part Of Family Income Is Spent for Health

Income	Spent
Under \$2,000	6.1%
\$2,000-\$3,499	4.0
\$3,500-\$4,999	3.9
\$5,000-\$7,499	3.6
\$7,500-\$9,999	3.2
All incomes	4.1



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er, 1 million have been charged amounts equal to at least half their incomes. And some 500,000 of these have medical costs equal to their entire incomes.

Does health insurance soften the outlines of this picture? Only partially, says the foundation. Its figures show that voluntary insurance comes closer to providing complete coverage for hospital costs than for medical costs: Half the nation's hospital

bill of \$2 billion is covered by insurance, as against only 13 per cent of its \$3.8 billion doctor bill.

Examining the insurance figures from another angle, the report notes that 59 per cent of families with some hospital-care insurance have most of their hospital bills covered. But only 45 per cent of families with some surgical-care insurance have the bulk of their surgical bills covered.

[MORE→

Families with health insurance spend 4.9% of their incomes on health

Families without health insurance spend 2.9% of their incomes on health

How Much Are Health Services Used?



How Insurance Affects Volume of Surgery

Family Income	Procedures Per 100 Persons	
	Insured	Uninsured
Under \$2,000	9	4
\$2,000-\$3,499	8	4
\$3,500-\$4,999	7	4
\$5,000-\$7,499	8	5
\$7,500 and over	8	4
All incomes	7	4

*Each figure represents the number of surgical procedures per 100 persons, according to (1) income bracket and (2) whether covered by voluntary health insurance or not.

► Life insurance doesn't raise the nation's death rate. Nor are there more fires—legitimately, at least—because of fire insurance. But people who have health insurance apparently do make much greater use of health services.

Evidence of this is found in the

Health Information Foundation survey:

¶ The admission rate to general hospitals is about 12 per 100 persons per year. But "those with some insurance show a rate of 13 and those without insurance a rate of 10. On a national scale, the difference be-

How Insurance Affects Hospital Admissions

	Rate Per 100 Persons*	
	Insured	Uninsured
Family Income		
Under \$2,000	19	9
\$2,000-\$3,999	13	10
\$4,000-\$4,999	13	10
\$5,000-\$7,499	13	8
\$7,500 and over	11	12
Type of Locality		
Urban	12	9
Rural, non-farm	14	11
Rural, farm	17	9
All localities	13	10

* Each figure represents the number of hospital admissions per 100 persons, according to (1) income bracket or type of locality and (2) whether covered by voluntary health insurance or not.

tween 13 and 10 is a measure of the impact of hospital insurance on hospital admissions."

¶ Surgical-care insurance, likewise, stimulates the use of surgical services: Seven per cent of insured persons undergo operations each year, as compared with only 4 per cent of the uninsured. (These rates, incidentally, are about the same at all income levels.)

¶ In sharp contrast is the situation in dentistry, where health insurance is an almost negligible factor. One-third of the nation uses dental services each year; but since charges have to be paid out of pocket, family income level is a big factor in the amount of use. Only 17 per cent of those with family incomes under \$2,000 visit their dentists in the course of a year. But on the other hand, 56 per cent of those with family incomes above \$7,500 go to see their dentists.

Do these figures indicate that voluntary health insurance is being widely abused by patients and doctors? The foundation concedes the likelihood that there's "a higher proportion of so-called 'elective' surgery in the insured families and a higher proportion of 'emergency' or 'must' surgery in the non-insured families." But it refuses to speculate further than that.

"What is known with certainty," it says, sticking to its statistics, "is that given a greater accessibility to surgery, the surgical rate is 7 per 100 instead of 4."

Who Owes For Medical Care

Income Bracket	Percent of Total
Under \$2,000	10
\$2,000-\$3,499	17
\$3,500-\$4,999	17
\$5,000-\$7,499	13
\$7,500 and over	8
All incomes	10



How Great Is the Nation's Health Debt?

▶ At the end of each year, about 85 per cent of the population have paid their health bills without going into debt. But 7.5 million families wind up owing doctors and hospitals a total of \$900 million. In addition, these and other families have borrowed \$200 million to meet health costs.

Some statistics on "medical indebtedness," as the Health Information Foundation calls it:

{ The average family among those in debt owes \$121 for health services at the end of each year.

{ About 9 per cent of all families end the year owing something less than \$95 for health services; 3 per cent owe from \$95 to \$194; and 2 per cent owe \$195 or more.

{ While about 15 per cent of all families go into debt for health bills, 21 per cent of families with dependent children wind up in the red.

{ Medical indebtedness occurs in fairly equal proportions in all in-

come brackets up to \$5,000. Then, it falls off.

{ For the most part, indebtedness hits families with health insurance just about as hard as it hits those without insurance.

In discussing the problems thus raised, the Health Information Foundation points out that "being in debt is no novelty for the vast majority of American families." But it sees a big difference between installment buying of consumer goods and going into debt for various health services.

For one thing, it explains, few individuals can anticipate the total cost of medical care; so "systematic saving is not a solution." In addition, when treatment is required, "the consumer usually has no choice but to seek the necessary services, regardless of cost."

The solution? A continuing expansion of voluntary health insurance, says the report.

END

This Study Program Meets the G.P.'s Needs

Do physicians in your state avoid post-graduate work because available courses conflict in timing or are hard to get to or impractical? Here's how doctors in one area have found a solution

By Michael Lesparre

● "Sure, I want to keep up professionally. I'd like nothing better than to do a lot of post-graduate work.

"But how to find courses that will fit into my time schedule? How to make sure that those I take will be of practical value? And how to get the instruction without an undue amount of traveling?"

PANEL SESSIONS, like this one held at Boston's Beth Israel Hospital,



You've heard that complaint often enough. Maybe you've made it yourself—and with good reason.

But, taking the country as a whole, there's less justification for grouching than there used to be. Continuation courses tailored to the needs of the average general practitioner show promise of becoming, in time, the rule rather than the exception.

One state where things look especially promising is Massachusetts.

As recently as three years ago, Bay State G.P.s who wanted to do post-graduate work found themselves up against a confusing situation. Many of the courses were poorly planned and at inconvenient locations; and there was often little or no coordination among them. As a result, disgruntled practitioners began to bombard the state medical society with complaints like these:

"There are so many courses in the Boston area that it's impossible to know where or when they're offered" . . . "I missed three good courses last year because I didn't hear about them in time" . . . "I'm about to give up; post-

satisfy the need of Massachusetts M.D.s for strictly practical courses.





CHIEF COUNSELOR on facts about post-graduate courses, is energetic Min. Charlotte Troutwine, who set up a new course-finding system for busy doctors.



PANEL ON CARDIAC DISORDERS includes top Boston specialists. Left to right they are Dr. Robert E. Gross, the surgeon-in-chief at Children's Hospital, Dr. Benedict F. Massell, research director of the House of the Good Samaritan, and Dr. Alexander S. Nadas, cardiologist at the Children's Medical Center.

graduate courses are too long and detailed" . . . "I can't spare six hours to travel to Boston."

Recognizing the acuteness of the problem, the society gave its committee on post-graduate medical education the biggest order it had ever had. It was told to make an all-out effort to produce "the most practical, most convenient post-graduate program ever planned for G.P.s."

The committee got swiftly to work. Its first job, it soon decided, was to set up a central information desk—a clearinghouse for post-graduate information. And it began, sensibly, by concentrating on the Boston area only.

There, with the financial help of local medical schools and hospitals, the committee established a Post-graduate Medical Institute. Its initial purpose: to classify post-graduate courses in the area and to iron out schedule conflicts.

This was a big job. But not too big, luckily, for Mrs. Charlotte Troutwine, an energetic former medical secretary, who was asked to carry it out. With a small clerical staff, she listed and cross-indexed all post-graduate courses in and around Boston. Then she organized and compiled the sort of information doctors would need: subject matter of courses, names of teachers, locations, hours, costs, etc.

The hard-earned result has been to bring order out of confusion.

Today, any doctor in the Boston area who'd like to take a course in,

say, peripheral vascular disease can generally find one by making a single phone call. Or, if he prefers, he can visit the Postgraduate Medical Institute in person. The service is, so to speak, free.

And that isn't all. The institute will also tell him the location of medical conferences, clinics, and special assemblies. If he wants monthly course listings, he can get them by mail at no cost (yearly listings: \$1).

How have the doctors reacted to this service? In the words of one of them: "It's the best reference system since the medical dictionary."

But this is barely half the story. The information center was only the beginning. The next step was to devise an assortment of courses geared especially to the G.P.'s needs.

As one institute planner put it: "The G.P. wants case histories he can learn from and pointers he can put to use in his daily practice. He wants short, compact courses that don't bog down in theory. Above all, he wants a fresh point of view on diagnosis and treatment."

It wasn't easy to arrange a program that would meet all these needs. Faculty had to be recruited. Support—moral and financial—had to be enlisted. And G.P.s themselves had to be consulted.

Fortunately, fourteen medical schools and hospitals in and around Boston backed the project from the start. Many well-known teachers volunteered their services. [MORE→

THIS STUDY PLAN MEETS G.P.'S' NEEDS

So, within a few months, the institute had a blueprint for a fifty-hour brush-up course for G.P.s. Its stated purpose: "to provide panels of specialists who will concentrate on the practical and avoid the theoretical."

The course as first offered consisted of twenty-five two-hour, Wednesday evening sessions in a variety of subjects: cardiology, obstetrics, gynecology, pediatrics, orthopedics, general medicine, etc. Physicians could subscribe for part of the course at \$30 or for the whole at \$50. Either way, they learned, the study hours would count toward the P.G. requirement of the Massachusetts Academy of General Practice (150 hours of post-graduate work every three years).

It isn't surprising, then, that local doctors quickly endorsed the program. Some 220 physicians (92 per cent of them G.P.s) subscribed immediately. What's more, many of them came from far corners of the state.

G.P.s Pleased

"It's the most sensible course ever devised for the busy practitioner," said one registrant. Other sample reactions:

¶ "Now we're on the right track. With panel discussions of cardiac emergencies, management of pains in the chest, and medical treatment of arthritis, you're speaking the G.P.'s language.

¶ "Even when we family doctors

read our medical journals, we feel better qualified if we also get information straight from the experts, as in courses like this."

¶ "I'd been out of school twenty years and hadn't taken any courses at all until this one came along. I can see already that it will be a valuable refresher for me."

There were inevitable flaws in the program that first year: Some of the meetings started late. The auditorium was often overheated. Speakers forgot to announce five-minute breaks. Some of the question periods were dull. One or two instructors were so carried away by their subjects that they droned on and on and on. One busy specialist brazenly read a treatise he had written several years earlier.

But the planners were determined to overcome such faults and to insure a hard-hitting teaching program. Mrs. Troutwine asked for unsigned comments from all students and instructors. With these as a guide, she drew up a set of suggested dos and don'ts for the teaching staff.

For example, she urged every panelist to prepare an outline of his discussion and have it mimeographed by the clerical staff at the institute. She tactfully advised inexperienced teachers to rehearse lectures before giving them. And she offered some sound advice about subject matter:

Truly practical courses, she pointed out, are based on only the most

specific diagnostic and therapeutic data. She also recommended strongly the use of visual aids, case histories, and (whenever possible) presentations with actual patients.

Finally, she stressed the advisability of intermissions and question periods; of promptness; and of constant checks on loud-speakers, lights, and ventilation.

Teaching Improves

As a result of these and similar tips, many of the panelists began to re-examine their teaching aims and methods. A dermatologist says he asked himself questions like this: "Even if a rare disease like discoid lupus erythematosus is important to me, is it really of much interest to G.P.s?" Another specialist decided that his hospital charts and graphs weren't easy enough to follow, so he drew up some new ones.

There were other changes, too: Speakers agreed to cover less ground in single sessions. Question periods grew longer and more profitable. Discussions became more lively.

When the program was a year old, the panelists and G.P.s alike agreed that it was a remarkably healthy baby. Only one troublesome problem remained:

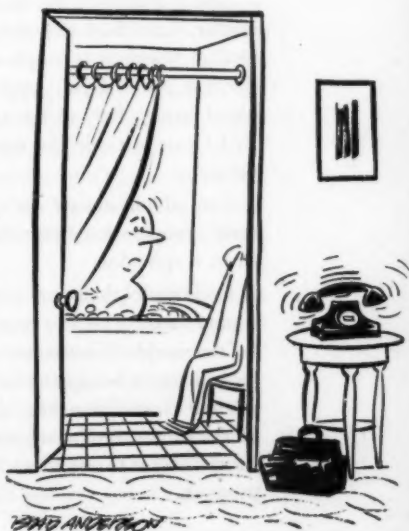
Many doctors weren't taking advantage of the course because of its distance from their home towns.

True, some out-of-town G.P.s had managed to get to Boston on Wednesday evenings. (Dr. Bernard H. Burbank of Portland, Me., drove

down each week. "This opportunity to hear the views of specialists in every field is well worth the trip," he said.) But for most doctors the prospect of a long weekly drive was certainly an enthusiasm-dampener.

Field Program

So the institute decided to expand its program by offering continuation courses in such "far-away" places as Pittsfield, Holyoke, and New Bedford. Since, obviously, all the Boston courses couldn't be repeated, the physicians in these areas were asked to choose topics of greatest local interest. They were also permitted to decide on the most convenient times for [MORE ON 251]





Who Will

By Wallace Croshaw

● To many Americans, the terms "blood bank" and "Red Cross" go hand in hand. This is scarcely surprising, in view of the dominant position of the Red Cross in the wartime blood program.

Blood collection for civilian use, though, is another matter. Less than two-fifths of the blood that flows to civilian hospitals is supplied by the Red Cross. Most of the rest comes from nonprofit community and hospital blood banks. But, as far as doctors are concerned, the Red Cross is easily the most disturbing element in the picture.

Not *all* physicians are hostile, of course. Here and there, cooperation between medical men and the Red Cross is splendid.

In Philadelphia, for example, the president of the county medical society recently described the Red Cross as "the world's finest benevolent organization" and urged his colleagues to support its blood-collection drive. In the town of West Plains, Mo., doctors threw their weight behind a fund-raising campaign that enabled the local Red Cross chapter to remain in the Springfield regional blood program.

Will We Run the Blood Banks?

The struggle for control between the Red Cross and medical men seems likely to go on, even though many sober voices are urging cooperation

Red Cross officials claim that such cooperation is the rule rather than the exception.

But is it? In some places, at least, medical men have been feuding openly with the Red Cross for years. For instance, take Houston, Tex., which is one of the few major cities that had no Red Cross blood bank even during World War II:

In November, 1950, the Harris County Medical Society agreed to the formation of a Red Cross center, which was to begin sending blood from Houston donors to Korea within three months. Nine months later, the program still hadn't gone into effect. So the doctors withdrew their support and set up a privately operated, nonprofit blood bank.

A Houston medical leader has explained the society's stand this way: "The purpose of the Red Cross regional centers seems to be not only to collect blood at the taxpayers' expense, but to draw it from volunteer donors, process it at the expense of generous financial contributors, then give it without charge to whoever needs it, regardless of ability to pay for it or to replace it. This is a give-away program, pure and simple, and it's designed

WHO WILL RUN THE BLOOD BANKS?

for peace as well as war. Such a program simply can't be justified."

California is another place where anti-Red Cross sentiment runs high. Medical men there speak of "a distinct lack of cooperation" shown by the local Red Cross office. As a case in point, they cite a territorial agreement reached last spring between the Red Cross and the Blood Bank Commission of the California Medical Association.

'No Cooperation'

"The idea was that local medical societies were to have the right to decide who should do the blood collecting in their respective areas," says a spokesman for the C.M.A. "But the Red Cross disowned the agreement almost as soon as it had been made. It moved into a territory assigned to one of our own blood banks and drew blood on a military reservation, without notification to the C.M.A. or to the county society.

"Its excuse was that it had been 'requested' to draw blood at that point and couldn't ignore a call from the military. This despite the availability of private nonprofit blood-drawing facilities."

Another man close to the California blood-bank situation speaks bitterly of "the long history of broken agreements, violations of territorial lines, and 'dog-in-the-manger' attitudes of the Red Cross." He adds: "Our only solace is that our community blood banks are continuing

to do what they originally set out to do: namely, to serve people with blood on a nonprofit basis."

Why Doctors Object

When medical men criticize the Red Cross blood program, their arguments generally revolve around four main points:

1. *The Red Cross shouldn't be collecting blood in the first place, since it isn't a medical institution.* Some doctors charge that the organization is interested in blood more for its prestige value than for its therapeutic value. Others say that the Red Cross isn't sufficiently interested in promoting blood research.

2. *The program will eventually dry up because patients aren't required to replace the blood they get.* It's true that a number of local Red Cross centers have worked out systems for crediting individuals and groups for advance donations. But once a person has been given Red Cross blood, he's under no real compulsion to pay it back. Unlike almost all community and hospital blood banks, the Red Cross refuses to levy a charge against patients who fail to replace blood.

3. *By creating the impression that it distributes "free" blood, the Red Cross tends to make people expect "free" medication and "free" treatment in general.* Whatever the public infers, say some doctors, Red Cross blood isn't free. For blood for defense, the Government pays the Red Cross the audited cost of col-

lecting it (roughly \$5.25 a pint) and the organization itself spends from 75 cents to \$1 a pint for "intangibles" (canteens, publicity, etc.). For blood for civilian use, the Red Cross pays the entire cost—out of funds contributed, of course, by the public.

4. *Red Cross blood-procurement is based on a "don't-let-our-fighting-men-down" approach not suited to collections for civilian use.* In fact, critics charge, the Red Cross has managed to stock its civilian blood so far only because of the emotional tie-in with wartime and defense needs.

Red Cross Rebuttal

As you'd expect, the validity of each of these arguments is vigorously denied. Dr. David N. W. Grant, who heads the Red Cross blood program, is especially incensed at the charge that, in effect, his organization practices medicine without a license.

"I'm an M.D.," Dr. Grant points out; "and so is the director of every regional blood program. We never start a community blood program unless we have the request, approval, and active cooperation of local medical organizations. All our regional programs have the benefit of the advice of local medical advisory committees."

Moreover, he adds, "about 180 Red Cross chapters take part in programs that are not included in the forty-five regional programs. This is

a cooperative effort among the local Red Cross chapters, the local medical organizations, and the local hospitals. Sometimes, too, the Red Cross has assisted in opening local blood banks in which the operation is entirely in the hands of the community concerned."

Can the Red Cross keep meeting its quotas without requiring blood replacement? Dr. Grant maintains that it can; and to support this view, he points to past history.

During World War II, he recalls, the Red Cross organized thirty-five centers throughout the country and collected more than 13 million bottles of blood. Its record during the Korean conflict was equally impressive.

'More Than Enough'

"By the end of 1952," he says, "we were taking in blood at the rate of over 4 million pints a year for civilian and military use. That's more blood than is needed by the entire civilian program!"

Would the Red Cross be able to maintain such productivity in a time of prolonged peace? Dr. Grant believes it could. "The public is getting more aware of the need for blood every day," he says.

He concedes that war-charged emotions figured prominently in appeals in recent years. "But I'd like to point out," he adds, "that the National Advertising Council has handled the actual publicity for the National Blood Program—and the Red

WHO WILL RUN THE BLOOD BANKS?

Cross is only one member of that program."

As for the expression "free blood," Dr. Grant insists that this is used not by the Red Cross but by "those in the medical profession who oppose our program." All the Red Cross has said, he maintains, is that "this is blood which has been freely given to the Red Cross and which the Red Cross donates without cost to the recipient."

How It All Began

So much for the argument over Red Cross blood policies. A question often asked is: How did a lay organization come to assume so prominent a role in blood banking in the first place?

Actually, the answer is quite simple: When the need for a national blood program became apparent in the early Forties, the Red Cross was ready and eager to take charge. The medical profession apparently was not.

As a matter of fact, most doctors cooperated willingly enough with the Red Cross during World War II. And, certainly, the organization did a creditable job of filling its wartime assignment. Thirteen million bottles of blood can't be dismissed lightly.

When the war ended, the Red Cross at first curtailed its blood-bank activities. But the medical profession showed no great eagerness to take over the work and to stake out its natural claim to the collection of blood for civilian use.

To be sure, there were exceptions: In some areas, doctors did help start community-wide blood banks. But no great effort was made, during the early post-war years, to tie these local ventures together on a national scale.

Red Cross by Default

So the Red Cross decision to go into civilian blood banking in a big way was perhaps inevitable.

The organization reached this decision in mid-1947; and on Jan. 12, 1948, it opened its first civilian blood bank. Two years later, the Korean emergency forced the machine into high gear—and it has been gathering momentum ever since.

Meanwhile, organized medicine has been notably hesitant about plunging into blood banking. The A.M.A., for example, has generally kept on the sidelines. Sometimes it has criticized Red Cross policy; sometimes it has endorsed it; sometimes it has tried to referee disputes between the organization and community blood banks. But it has never been quite willing to step into the ring itself—until recently.

A.M.A. Takes a Stand

Last June, the association finally made an active move: On a resolution submitted by California doctors, the House of Delegates voted to "urge the establishment of a coordinated national blood-bank program organized by the American Medical Association, the American National

Red Cross, and other qualified organizations interested in blood banking."

A.M.A. participation in the project was to depend on two provisos: that "medical aspects of blood banking shall be under the exclusive control of the medical profession"; and that "the supply of blood shall be maintained on a replacement basis."

Since then, a number of meetings have been held among the Red Cross, the A.M.A., the American Hospital Association, the American Association of Blood Banks, and the American Society of Clinical Pathologists—with a noteworthy lack of progress. All parties have agreed to cooperate in setting up a coordinated blood program. But negotiations drag on.

Speaking for the Red Cross, Dr. Grant expresses "high hope" for the proposed program; but he adds that the day when it will become a reality "certainly isn't near." A medical-society representative says flatly that coordinated blood banking "is totally impossible at this time." And a spokesman for the community blood banks gives his explanation of what's wrong: "The Red Cross is approaching the conference table not with the idea of what it can contribute to the program but of what it can get out of it."

Some Hope of Success

Fortunately, there is optimism in some quarters. One active worker for a coordinated program is Dr.

Robert Lee Dennis of San Jose, Calif., who drew up the resolution that the A.M.A. adopted in revised form. He foresees the day when the A.M.A. and the Red Cross will play key roles in such a program. The A.M.A., he expects, will handle the "professional and technical functions"; the Red Cross, the "business and administrative functions."

The two organizations, Dr. Dennis believes, "are admirably suited to the performance of joint blood banking. The A.M.A., through its components, is well spread throughout all segments of the American people; the same can be said of the National Red Cross. Both organizations are committed to the service of the people; both are respected and accepted."

How a Joint Plan Works

As proof that doctors and the Red Cross *can* get along, Dr. Dennis points to his own area—Santa Clara County. There, he says, the county medical society and the Red Cross chapter have jointly run a blood bank since 1948.

Though the plan has at times "operated in the face of opposition from segments of both organizations," Dr. Dennis claims that it has worked out remarkably well. The main reason for its success, he feels, is that both sides have shown a willingness to soft-pedal their special interests for the sake of the program in general.

In the very beginning, he points out, local medical [MORE ON 254]



XUM

If Fire Strikes, Will Your Policy Pay Off?

Whether or not your insurance proves adequate in a pinch will depend largely on factors like the small print in the policy, the man you bought it from, and the records you've kept

By Wallace Croatman and Michael Fooner

● Collecting on a fire insurance policy may seem a simple procedure. But a number of doctors who have had fires will vouch for the fact that it isn't.

Your chances of getting a satisfactory settlement depend largely on four main factors:

1. The kind of policy you have;
2. The company and broker you bought it from;
3. The records you've kept; and
4. The way you make your claim.

You'll do well to consider these points *now*. So let's examine them one by one:

1. Kind of Policy

In weighing the adequacy of your policy, you can begin with an obvious question: Does it cover all the property likely to be damaged?

Actually, the ordinary fire policy covers a good deal: not only the basic structure but also floor coverings, window shades, awnings, screens, storm doors, storm windows, and attached structural additions. [MORE→]



Fire may have completely wrecked your home or office—but it's no guarantee that insurance will cover your entire loss.

It also provides some coverage on outbuildings. But in this respect, your insurance *may* be inadequate. Reason: The average policy covers such structures only up to 10 per cent of the value of the insurance on the entire property.

Not long ago, a doctor in the Southwest learned this, to his sorrow. He had built on his property a

garage equipped with second-story living quarters. The structure was worth about \$4,000. When it burned down, the insurance company pointed out that its liability was limited to 10 per cent of the total value of the policy; and it paid the physician only \$2,000.

How could the doctor have assured himself of the extra protection

IF FIRE STRIKES

mentioned in the policy—and pay an added premium. This applies in particular to shrubbery, fences, and the like.

In addition to the coverage you carry on your home and office, you undoubtedly have policies for your professional equipment, as well as on your household furniture and personal effects. Such policies, you'll find, insure the entire contents of a house or office, excluding items like accounts, bills, currency, deeds, or securities. If you'd like, you can insure your accounts under an accounts-receivable policy and your money and securities under an all-risk money-and-securities policy.

So much for the matter of coverage in general. Next, it's important to know what specific causes of damage your property is insured against.

The basic policy, of course, covers damage by fire and lightning. But what, exactly, does that mean?

The term "fire" applies only to so-called "unfriendly" fires—not, that is, to "friendly" fires like those in fireplaces and stoves. So if somebody drops a valuable item into your incinerator, say, don't expect to be reimbursed for the loss. (Nor, obviously, can you smoke a box of expensive cigars and bill the insurance company for the replacement cost—as one wag tried to do.)

But if a friendly fire leaps over a fire-screen and burns a coffee table, it has stopped being friendly, and you can probably collect. You can, that is, if the coffee table actually

he needed? By having his garage-apartment itemized in his policy with a specific value placed on the building. His over-all premium would have been higher this way, of course; but it would obviously have been worth it.

By similar means, you can protect other special features of your property. Simply have them specifically



If your town requires badly damaged buildings to be torn down, you'll want a demolition clause in your fire insurance policy.

burns. It's not enough for it simply to be slightly scorched.

Where there is an unfriendly burning flame, *all* damage caused by the fire (including water, explosion, blistering, heat, charring, and smoke) is covered. It's worth noting, too, that many companies pay the cost of repairing serious cigarette burns in upholstery, even though a burning flame would be difficult to prove.

Chances are, your fire policy has an extended coverage rider providing protection (at extra cost) against windstorm, hail, explosion, riot, civil commotion, smoke, and damage by

vehicles or falling aircraft. Even so, there are still other contingencies that you may want coverage against.

Suppose, for instance, your office oil burner operates through a not very modern converted coal furnace. It may be a wise move for you, in this case, to get a rider covering smoke damage due to faulty furnace operation. (The usual policy, remember, covers only smoke damage caused by unfriendly fires.)

Or if your home has an ancient galvanized-iron network of water pipes, it's not a bad idea to insure against damage caused by their bursting. Or, again, if you're in a

community where regulations force the complete demolition of badly damaged buildings, better add a demolition clause to repay you for any loss of that type.

How Much Is Enough?

There's one more question to consider before you can feel sure of having proper coverage: Do you carry *enough* insurance?

At this point, let's define something that's often misunderstood: the co-insurance clause. This is a feature of almost every fire policy. In effect, it restricts the amount you can recover on a loss if you haven't insured your property for a given proportion (usually 80 per cent) of its over-all value.

To illustrate how co-insurance works, let's assume that a doctor has suffered a \$2,000 fire loss in an office insured for \$10,000. Unfortunately for him, the \$10,000 amount was settled on back in 1940; on the present market, the office is worth about \$20,000.

Although the doctor realizes that he's underinsured, he isn't worried—at first. After all, the damage in this particular fire has come to only \$2,000. His \$10,000 policy certainly covers that in full, doesn't it?

An Easy Mistake

No, the insurance adjuster tells him, it doesn't. Under the co-insurance clause, he explains, the doctor should have carried at least \$16,000 worth of insurance (80 per cent of

the present value of the office). Since he has only 10/16 of that amount, the company will pay just 10/16 of the loss. So the physician has to be content with \$1,250.

Unfortunately, it's easy to make a mistake of this kind. *You* may be underinsured, too—especially if (a) you bought a house before the boom in property values began; (b) you have recently made extensive improvements.

If you suspect that you're underinsured, have a talk with your broker. He can explain how the co-insurance clause applies to *your* situation. If there's some question of the current value of your property, have it appraised.

What Will It Pay?

To what extent will you be reimbursed for a legitimate claim? That's an important question—and a knotty one. The answer depends pretty much on the so-called "depreciation" factor.

For co-insurance purposes, values are figured on the basis of replacement costs. But that doesn't mean your settlement will enable you to replace your damaged property with new. This would be true *only* if you had a special "replacement" contract—and chances are you don't. More likely, the company will figure your loss at replacement cost *minus* depreciation on the damaged property.

To illustrate:

Suppose fire destroys the shingle

IF FIRE STRIKES, CAN YOU COLLECT?

roof on your home. A local contractor says he'll replace the roof for \$900. But the insurance company, while considering this a reasonable estimate, points out that the original shingles were ten years old and that the average life of a roof of this type is only fifteen years.

Since the old roof had only one-third of its life expectancy left, then, your loss is assessed at one-third the cost of a new roof. And the company will pay you only \$300.

Adjusters Hard-Headed

Insurance adjusters are wholly unsentimental when it comes to estimating the value of damaged property. They're less likely to be impressed by the fact that your burned woodwork was real chestnut than by the fact that it was thirty years old. A case in point is that of an East Coast internist whose office was destroyed by fire last fall.

It had been extensively redecorated two years before; and the doctor hadn't intended to redo it for another four years. Yet the adjuster insisted that he had already had half his money's worth out of the redecorating job. The argument dragged on for a couple of weeks—until, at last, the doctor gave in.

Special Policies

Property damage, of course, is only one of the financial losses you'd face if your home or office were destroyed. What about expenses like moving and boarding out if your

home should go up in flames? Many doctors have sensibly bought special coverage for just such risks.

One of them—whose home was made temporarily uninhabitable by fire—had good reason to be glad he'd taken out an "extra expense" policy. It covered the costs of living in a hotel and eating in restaurants until he and his family could move back.

Another medical man who carried a "use and occupancy" policy was equally glad: It reimbursed him for "inescapable, continuing expenses" of his practice when he was forced out of his fire-wrecked office. He was thus able to pay salaries to his nurse and technician right through the period of enforced idleness.

2. Company and Broker

Admittedly, some insurance companies are tougher to deal with than others. But it's seldom possible to tell how cooperative or uncooperative yours will be until you've had a loss.

Nor are you likely to find premium costs much lower in one company than in another: Rates for a given risk vary only slightly.

Some insurance counselors, however, advise dealing with a mutual rather than with a stock company, because the former, when all goes well, passes out dividends to policyholders. These counselors maintain that you can reduce premium costs

by from 15 to 20 per cent if you have your coverage with a dividend-paying company.

Often, though, choice of company is less important than choice of broker. If you have a reliable broker, you can confidently let him select the company for you.

A top-flight broker can help out in many ways. He'll study your insurance needs and advise you *sensibly* on what to buy. He'll answer your questions about co-insurance, depreciation, and the like. He'll be especially helpful, if you ever have a fire, in seeing that you get a favorable settlement.

3. Your Records

Even if you have the right kind of policies and the perfect broker, you'll find it easier to collect for damages if you can furnish an accurate listing of your property.

A well-kept inventory is the key to your claim for personal belongings, household furnishings, and professional equipment. And there's no way to get around the fact that the preparation of a good inventory is a difficult, never-ending job.

Ideally, an inventory of house and personal effects, for example, should list every stick of furniture. It should include all clothing owned by all members of your family. And it should mention the price of each item, as well as the date of purchase. This last information should, if possible, be bolstered by supporting

evidence like check stubs and sales slips.

It's true that the insurance adjuster will usually take your word, if your claims seem reasonable. On the other hand, he *may* want to check the prices and purchase dates of certain items with the stores where you bought them.

Undamaged Items

The inventory you make out today will, of course, list only undamaged items; but if fire strikes tomorrow, you'll want to make separate listings of damaged and destroyed property as well. For every destroyed or damaged item, you'll be expected to set down a reasonably close approximation of its original cost and its value at the time of the loss.

The value at time of loss—totaled for all your property covered by insurance—determines whether or not you have enough insurance to be fully covered under the co-insurance clause. So, in estimating the value of *undamaged* property, it's wise to take full account of depreciation, obsolescence, and any other factor that might cut down the insurance adjuster's appraisal of present value.

Damaged Goods

But this is only part of the story. Where *damaged* and *destroyed* goods are concerned, it's best to *hold down* the depreciation factor. Furniture in a spare bedroom, for example, may have been practically

IF FIRE STRIKES, CAN YOU COLLECT?

unused in the four years since you bought it; in your estimate, then, you can honestly value it at close to replacement cost.

Then, too, don't overlook possible *appreciation* of damaged property. A case of vintage wine, or an imported, prewar camera may be worth more today than when you bought it. If the adjuster questions your estimate, you can always give the company the option of replacing the article with one of "like kind and quality" instead of cash.

Fixing Payment

The amount you'll be paid for an item, then, depends on three things: its cost, its value at the time of the fire, and its current replacement value. The company subtracts its estimate of depreciation from the replacement value and pays the remainder—known as the "cash amount of loss." For example:

Say a runaway bonfire destroys a chaise longue, on your patio, that cost you \$100 five years ago. The company adjuster estimates that it had depreciated 50 per cent by the time of the fire. But he concedes that it would probably cost you \$120 to replace it today. So he offers to allow \$60 in settlement (replacement cost *minus* 50 per cent to cover the depreciation factor).

The secret of presenting a favorable inventory after a loss can be summed up in two bits of advice: (1) Don't *underestimate* the cash value of damaged property; and (2)

don't *overestimate* the value of undamaged property. But in seeking to follow that advice, your best bet is to have thorough records of your possessions.

It's a big job to keep inventories up-to-date in anticipation of a fire that you hope won't come. But it's worth the effort.

4. When Making a Claim

If you ever do suffer a fire loss, one of your first activities should be a careful reading over of your policy. This may seem like gratuitous advice; but it's vitally important. The policy will tell you specifically what you're required to do in order to collect. If you don't follow instructions, you run the risk of not collecting all you're entitled to.

Here are the major post-fire requirements of a standard policy:

¶ Notify the company or your broker of the loss.

¶ Protect the property from further damage, as far as possible.

¶ Separate damaged from undamaged property.

¶ Put all property in the best possible order.

¶ Furnish a statement of destroyed or damaged property, covering in detail such points as quantities, costs, actual cash value, and amount of loss claimed.

In addition to the above, most policies state that you must file a "proof of loss" statement within sixty days. This is a form showing your

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policy number, date of loss, and the amount; it's usually made out by the adjuster after you and he have agreed on the amount you're to receive. (You won't sign it, of course, until you're reasonably satisfied.)

The possible catch here is that the sixty days may run out before you and the adjuster come to terms. And though most companies don't ordinarily refuse to pay in such an event, they can use failure to comply with the requirement as a lever to force you to settle on their terms.

If you and the adjuster can't agree within, say, a month, file your own

"proof of loss" form with the company. Or ask for a written extension of time.

As I've already said, you're supposed to protect your damaged property from further deterioration or loss. For example, you'll be expected to get everything under cover. If necessary, you can incur some expense in doing this (such as hiring workmen to board up a building), and the insurance company will reimburse you. But you'll naturally want to get their approval before running up any major expenses.

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"Would you feel secure on an allowance
of two bits a week?"

'I'm For Co-op Medicine!'

After four years with one community-sponsored group health plan, this M.D. finds his income adequate, his professional standing high, and his patients pleased with their medical care

By William M. Featherston, M.D.

● About four years ago, when I'd completed my residency in pediatrics, my wife and I had to start from scratch. We were \$4,500 in debt, and the immediate future looked bleak—until I was asked to join the staff of a community-sponsored health plan at Elk City, Okla.

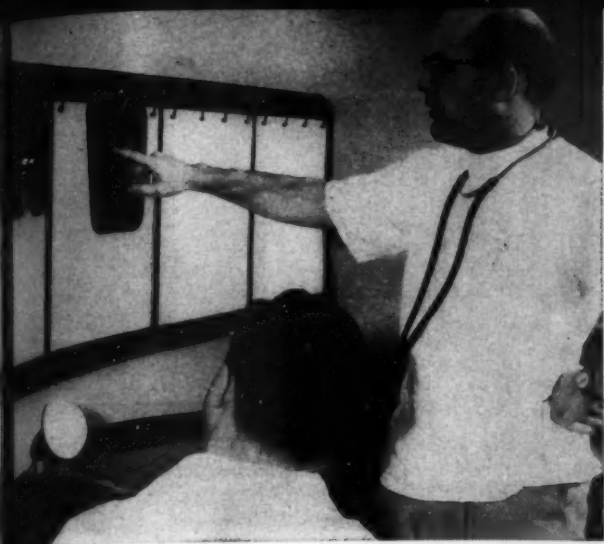
The idea of working for a salary—at least, for a while—appealed to me. The alternative was to go even more deeply in debt in order to begin private practice. And we were weary of living on hope and a shoestring.

But, like most young doctors, I had heard unpleasant rumors about medical cooperatives. So I decided to investigate thoroughly before accepting the Elk City offer.

I asked every question in the book. I examined every possible facet of the organization, both medical and economic. When I joined up, I knew what I was doing. And now, several years later, I'm sure I did right.

Much has been said and written about the disadvantages of cooperative health plans. As a partial counterbalance, let me tell you about the *very great advantages* of at least one of them—mine.

*A recent MEDICAL ECONOMICS article ("Good-bye to Co-op Medicine," August, 1953) made certain charges against community health plans. In keeping with their policy of presenting both sides of controversial questions when possible, the editors print Dr. Featherston's rebuttal.



A BIG ADVANTAGE of co-ops, says Dr. William M. Featherston (right), is frequent consultation with colleagues.

The Elk City Community Hospital-Clinic guarantees me an adequate income.

Is the co-op doctor exploited? Many medical men apparently think so. They contend that no matter how much medical care he contributes, he's always held within the limits of his salary. And they add that he often has to pay for equipment and supplies he doesn't even use.

Maybe so. But not in my group. Originally, I was offered a starting salary in keeping with my experience; and I was promised regular yearly increases. In time, I was told, I'd be eligible for the same top salary as other specialists—and for annual bonuses, too.

It was all true. I netted nearly \$9,000 the first year, and \$11,000 the second year. Since then, my income has been steadily rising.

[MORE→]



UP-TO-DATE co-op hospital has every facility, claims Dr. Featherston. At the blood bank [▲] he checks supply with Curtis Britton, technician. June Conrad [▼] uses new spectrophotometer to measure sodium content of blood serum.



The bonus isn't a myth, either. And that isn't all. At no cost to the doctor, our co-op provides a pension plan and income insurance against illness.

I have a well-equipped office, plus all the facilities my patients need for first-rate care.

Our town is small (pop. 8,000). Yet the Community Hospital-Clinic laboratory, for instance, is as good as any I've seen in big cities. My office is spotless and new. Our equipment throughout is up-to-date and more than adequate. We even have our own well-organized blood bank.

What's more, the clinic and 75-bed, air-conditioned hospital are fully paid for. We doctors pay no rent for our use of the physical plant, which is owned by the Farmers' Union Hospital Association. (The two staff dentists, however, are



SELF-SUPPORTING, the Elk City (Okla.) co-op includes a 75-bed air-conditioned hospital (*at left*) and a new, ultramodern clinic.

charged a percentage of their gross income.)

Must any of us sacrifice good care for the sake of bargain medicine? Not to my knowledge. Some critics say that co-op hospitals are generally run like factories, in order to cut down expenses. Well, I wish they could see ours.

As staff pediatrician, I'm particularly proud of the polio ward, with its respirator equipment, whirlpool and paraffin baths, and deep tub bath. When I need any such facilities, the directors get them for me. They've never turned down a request of mine for additional nurses, equipment, or supplies!

The practice of cooperative medicine has proved no drawback to professional recognition.

I was frankly afraid, at first, that I might be barred from many organ-

ized activities in medicine as a result of joining the Elk City group. But I needn't have worried. Here are some significant facts:

¶ I'm a member in good standing of my county and state medical societies—as is every M.D. on our staff; I have been certified by the American Board of Pediatrics; and I was invited, last spring, to become a member of the Rural Health Conference for the State of Oklahoma.

¶ Our hospital has been granted provisional approval by the Joint Commission on Accreditation of Hospitals. (We expect full approval this year.)

¶ My colleagues and I are adequately covered for malpractice. There's no fine print that limits our coverage simply because we're members of a co-op staff.

My colleagues are first-rate doc-

'I'M FOR CO-OP MEDICINE!'

tors—and fine men to work with.

It has been said that the truly competent physician is seldom willing to exchange private practice for salaried work with a co-op. The idea seems to be that he won't "stoop" to so-called commercialized medicine.

Such comments are clearly biased. The co-op doctor, I've found, has a better chance than the average private physician to live up to professional standards. Chief reason for this: He can give more time and attention to medicine and less to economics.

Consultations, for instance . . . My colleagues and I consult freely throughout the day. As many as seven of us have got together in a single consultation. Thus, it seems to me, we're given a unique opportunity to learn—and to keep on learning.

Are co-op doctors an undependable lot, who frequently move from community to community, as critics sometimes say they do? Well, a few of our staff have moved away—but only as doctors will under any circumstances. One man left in order to complete a residency in radiology; another resigned, not long ago, to become the partner of a noted New York urologist.

But the rest of us—there are seven M.D.s and two dentists—stay contentedly on. True, one of our G.P.s quit, a couple of years ago, to join a "private enterprise" clinic in Arkansas. But he soon came back. He had liked the Arkansas weather, he said, but not the medical climate.

We're not, finally, dominated by law-enforcing laymen.

We have a lay administrator-business manager. But he's directly responsible to the medical director. So administrative edicts are never made without medical opinion and backing. And medical staff members are given a voice in all policy-making.

Our board of directors this year includes an insurance salesman, a county commissioner, a high school principal, a farmer, and a retired hardware merchant. The medical staff attend all their meetings. There's little chance for adoption of any policy that might endanger the subscribers' health interests.

The plan is self-supporting. Members pay an initial \$100, plus annual dues (\$18 for an individual; \$30 for two persons; \$36 for three; \$40 for four). And they're encouraged to speak up if they disapprove of any decision of the governing board.

In other words, the Elk City Community Hospital-Clinic is a truly democratic organization.

One Drawback Seen

In essence, co-op medicine is like any other group medicine. But I've found that it has a broader scope than noncooperative group practice. Not only does it bring specialists to small towns like Elk City but it also cuts the costs of superior medical care. And it has a special value for the doctor: He gets *paid* for practicing preventive medicine.

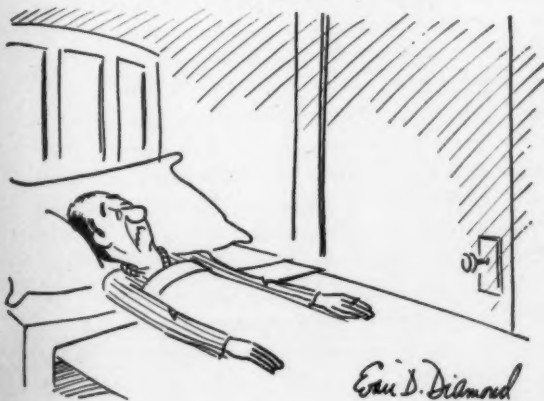
Disadvantages? In four years, I've discovered only a single major one: the prejudice that many private doctors harbor against community-sponsored health plans.

I'm glad I no longer share this prejudice. Doubtless, some co-ops aren't entirely successful. But should all be blamed for the inadequacies of a few?

END



"The insurance adjustor's coming!"



Evan D. Diamond

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Company and Private M.D.s

Here's a two-sided view of major sore spots in a conflict

● Not long ago, I asked a general practitioner in a New England factory town to tell me about the biggest problem he faced. His response was long and detailed; but it could be boiled down to two words: "industrial doctors."

In gathering material for this article some weeks later, I asked the medical director of a large floor-covering company what *his* main problem was. "Private physicians," he immediately replied.

Though the careers of these two men may have little in common, their remarks serve to point up a question of concern to all doctors: How to relieve the irritations that so often mar relationships between industrial and private M.D.s?

The frictions aren't a recent development, of course; but they appear to be growing as the number of physicians with a stake in industrial medicine grows. So let's take a look at some causes (and a possible cure).

As far as private doctors are concerned, perhaps the No. 1 irritant rises from the amount of treatment that industrial M.D.s give workers who might otherwise consult family physicians. Here, for instance, is a case that illustrates a typical family-doctor complaint:

A worker in an electronics plant—I'll call him Ed Wilkins—is subject to headaches, colds, and sundry other disorders; but he hasn't visited his neighborhood G.P. for years. Instead, he regularly takes his symptoms to the plant dispensary.

[MORE→]

M.D.s *Must They Feud?*

By Michael Fooner

a conflict of growing importance—with one suggestion for easing the pain



He likes the arrangement because there are no doctor bills, he often gets free medication, and he's treated on company time. Moreover, if the plant physician tells him to take things easy for a few days, he has a built-in excuse for staying home at company expense.

As the Doctors See It

Under the circumstances, you can hardly blame Ed for approving of the set-up. Nor, perhaps, can you blame the plant physician for taking a rather broad view of what constitutes an industrial case.

"If it weren't for our program," he says, "Wilkins wouldn't get *any* treatment for those minor ailments; he'd never consider seeing his own doctor until he got really sick. This way, I keep an eye on him and he loses relatively little time from work. He's happy, and so is the company—since he's of no use to us, certainly, when he's laid up."

But Wilkins' family doctor sees this attitude as a potential threat to his practice. "It may be all right when Wilkins has a cold," he points out. "But what about more serious illnesses? Seems to me that all too many industrial doctors treat cases that are miles beyond their province."

Candidly, plant physicians admit that some company medical programs do cover too much ground. But they deny that this is the general rule. As one full-time company man puts it:

"By and large, we have no real reason to compete with the private practitioner. Most of us are paid by the hour—not by the case. And we're usually hired for a rather specific purpose: maybe to conduct periodic physical examinations, maybe to work out an accident-prevention program.

"Since our compensation is usually related to how well we perform that job, we have nothing to gain by trespassing on the private doctor's domain. In fact, we're only too glad to consult another M.D. when we find an employee with a heart condition, hemorrhoids, or whatnot."

Actually, some industrial men claim, they're more likely to act as feeders than as competitors to the private physician. Says Dr. Robert Collier Page, president-elect of the Industrial Medical Association:

"The industrial doctor, through his program of employee examinations and periodic check-ups, discovers conditions that would otherwise remain unknown to the employees, and he sends them to their family doctors or physicians of their own choice. Thus he expands the 'demand' for outside practitioners' services—helps to develop practice for them that they wouldn't get otherwise."

Build Own Practice?

Dr. Page is speaking primarily of the full-time industrial doctor. In the case of doctors with only part-time roots in industry, another cause of

controversy often pops up: the question of the self-referral.

"Some doctors regard industrial work as nothing more than a practice-building device," an irate G.P. recently told me. "If they don't steal patients from their colleagues, it's only because they've found enough workers who have no family doctors."

"I knew a man once who actually handed out cards containing his private office hours and address. You can't do much about somebody like that. Ethics? They're only as binding as your conscience makes them. Anyway, the practice-building doctor can usually rationalize his behavior. He looks at you blandly and asks, 'How can I turn away somebody who wants *me* for his physician?'"

Some companies, it's true, forbid their physicians to accept employees or their families as private patients. But generally only the bigger concerns do this. The typical small plant (the one, in other words, most likely to hire a part-time physician) rarely has any such restriction.

All or Nothing?

Because of the complexity of the problem, some doctors despair of trying to solve it. Others argue that no physician should go into industrial medicine on a part-time basis. They maintain that the man who isn't willing to give all his time to the field should stick to private practice.

This is hardly a realistic view, of

course. In some areas, there's only a single industrial plant—and it probably can't afford a full-time physician. Moreover, though a number of doctors may have every intention of going into full-time industrial practice, they sensibly prefer to work into it gradually.

"I have a contract to set up a company health and medical program," one such man explains. "If the idea takes hold, I'll be happy to devote all my time to the job. But the company isn't yet sure that it will be able to finance a full-time program. So, for the next two years, I'm going to work pretty much on a trial basis—three hours a day, three days a week. For the time being, I've got to keep up my private practice."

The Direct Approach

Even if an industrial doctor does not refer patients to his own private office, does he tend to "short-circuit" the G.P. by sending workers directly to specialists? Some general practitioners insist that he does. And there's certainly some reason for this complaint.

In one large East Coast plant, for example, a recent check revealed that seven out of every eight referrals were going either to specialists or to hospitals!

But is such a procedure necessarily bad? The industrial men say it isn't—at least, not from their point of view.

"I have three main reasons for referring patients directly to special-



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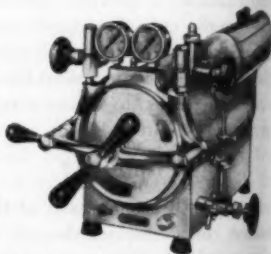
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ists," says one medical director. "In the first place, there's the need for legal safeguards: If there's a chance that our company will be sued in a particular case, we like to have the word of a top specialist behind us.

"Then there's the question of time. We want our workers back on the job as soon as possible. So why should we waste time referring the patient to a G.P. if we already have a good idea of what's wrong with him?

"Finally—and this, I know, is a touchy matter—there's the question of expense to the patient. We don't think an employe should have to pay an extra fee simply to hear our diagnosis confirmed."

G.P.s Not Competent?

Some industrial doctors, too, apparently lack confidence in the G.P.'s ability. One plant physician, in explaining this attitude, recalls the case of an employe who, returning to work after a two-week absence, brought a note from his family doctor saying he'd had pleurisy. Following standard procedure in that company, the industrial M.D. ordered a chest X-ray taken. It indicated a possible lung cancer.

The patient's doctor was immediately notified; but he evidently did nothing to follow up the case. "Finally," says the plant physician, "I myself ordered the employe hospitalized.

"I suppose," he adds, "that a certain G.P. in our neighborhood now

thinks I go around stealing patients!"

The question of certification of workers' ailments is a frequent bone of contention among industrial and private physicians. To get the industrial doctor's viewpoint, listen to Dr. Leo J. Wade, medical director of Esso Standard Oil:

"It's a curious fact that private M.D.s sometimes certify workers as disabled just as long as their full-pay sickness benefits are available. The day those benefits expire, the worker experiences a miraculous recovery—which is also certified to by the physician."

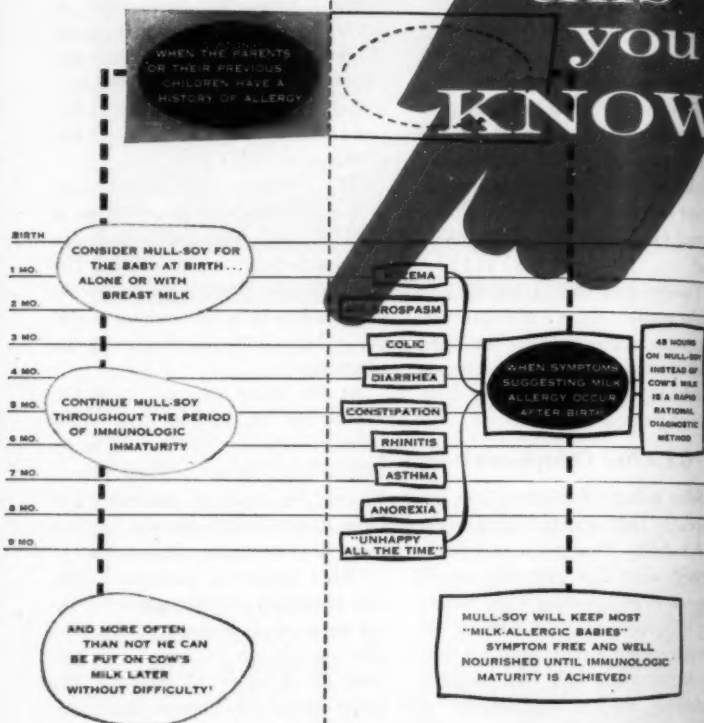
At the other extreme, adds Dr. Wade, are the doctors who allow patients with serious illnesses to return to work too soon. These practitioners, he charges, evidently believe a worker's economic welfare more important than his health.

Other industrial physicians criticize their private colleagues for being too ready to blame a worker's injury on his job. Take an employe with a back injury, for instance. The plant doctor may have reason to suspect that the worker got it from bowling, or from digging the foundation for his new house. But how can the company M.D. prove it—especially in the face of a conflicting statement from the family doctor?

Both Cry 'Collusion'

Says one medical director: "Private doctors are quick to accuse us of patient-stealing and equally hor-

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1. Clein, N. W.: Ann. Allergy 9:195, 1951.

2. Glaser, J., and Johnstone, D. E.: Ann. Allergy 10:67, 1952.

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rible crimes. But many of them see nothing wrong in sometimes perjuring themselves, in order to win their patients a favorable judgment from the compensation board."

Private physicians, for their part, retort that the plant doctor isn't always the disinterested party he claims to be. At times, they suggest, he may not be above helping to deprive an injured worker of a just claim.

"After all," reasons one family doctor, "it's an industrial physician's job to keep down accident rates. So, naturally, he'd rather have a worker's back condition passed off as a bowling heritage than as an on-the-job injury."

Much of the friction in this area probably springs from an honest misunderstanding of the other fellow's point of view. Consider this case:

Each Sees Only Part

Dr. K, a general practitioner, certifies that his patient is well enough to return to the auto assembly line after having had a double hernia repaired. Dr. L, the plant physician, disagrees. He knows that the worker has a strenuous job and that, if he can't hold up his end of the production line, materials will be wasted. As a consequence, management will probably raise hob with the medical department for having approved the man's return.

Dr. K, on the other hand, isn't at all sure of what an assembly-line job

entails. He has only his patient's word that "it's not too tough."

But he does know one thing: the medical director doesn't know that the worker has severe financial problems and can't afford to lose more time from work.

Obviously, each doctor has seen only part of the story. And that's generally the case in such situations. If the medical men can get together and compare notes, fine. Usually, however, they can't—or simply don't.

Steps Are Being Taken

What's doubtless needed, then, is a more cooperative attitude on both sides. Fortunately, medical authorities are learning to stress this fact. For example:

The A.M.A. Council on Industrial Health and the American Academy of General Practice have worked out a program designed to improve relations between industrial and private M.D.s at the local level. And two other professional societies—the American Academy of Occupational Medicine and the Industrial Medical Association—are encouraging the medical schools to establish and expand courses of study in industrial medicine.

A number of local medical societies, responding to A.M.A.-A.A.O.M. requests, now hold meetings, lectures, and symposiums on industrial medicine and its problems. In many areas, too, private physicians are being invited to visit local factories here, they're

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XUM

Investment Clubs Offer Knowledge, Profits, and Fun

Whenever a number of friends or acquaintances join together in a mutual investment program, there are probably M.D.s among those present

By Raymond Trigger

● From the tiny town of Island Falls, Me., near the Canadian border, Dr. Clyde Swett serves the medical needs of some 7,000 people in the pine-clad Katahdin Valley. He also runs a small, efficient hospital.

For many a physician, this would be enough. Not so Clyde Swett. He rides several active hobbies as well.

One of these hobbies has long been investing.

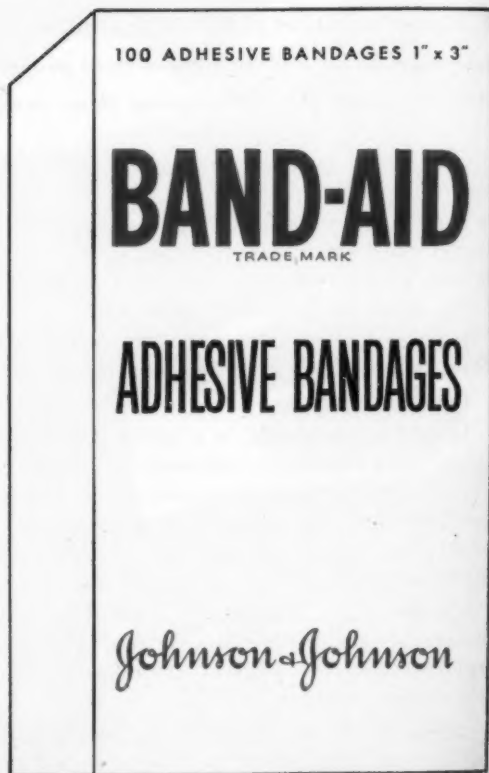
In the summer of 1952, at a local outing, he got to talking about investments with several of the men present—among them a lumberjack, a lawyer, and an accountant. He wondered if they wouldn't get some fun—and learn something in the process—out of putting \$20 a month each into a little investment pool.

The idea took hold. Those in on it talked it up among their friends. Within a few days, two dozen townspeople had banded together enthusiastically as the Katahdin Investors Club.

Once a month now, the club holds a combined business and pleasure session at a near-by hunting lodge. The first part of the meeting centers around a guest (a qual-

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1. De Lucia and Strosberg, Med. Times 82:1, p. 47. 1954.

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ified investment specialist) who talks about some practical aspect of market operation, then leads a round-table discussion. The second part of the meeting consists of a report from the club screening committee, followed by a decision as to what stock transactions are to be made for that month.

So much do the club members enjoy their sessions—and benefit from them, too—that already their ranks have doubled.

I estimate that well over 500 investment clubs are operating in this country today. The members of most of them, like those in the Katahdin club, meet once a month to learn how to invest successfully; to gain actual experience by contributing to, and running, a small fund of their own; and to enjoy one another's company.

How widely these clubs will spread is anyone's guess. So far, certainly, they've captured the enthusiasm and helped invest the surplus savings of a lot of people in a phenomenally short time.

One of the first investment clubs to get started was organized in 1940 by six young men in Detroit. They had just been graduated from college; jobs were scarce; and one of their main preoccupations was to try to assure themselves work in the future. Not realizing that Uncle Sam would recruit all six of them within the next year or so, one of them came up with this suggestion:

"One way to be sure of work is to start our own business. Let's pool a

few dollars each month until we have enough to finance ourselves. As the money accumulates, we can invest it."

Profits for Fourteen

This is precisely what they did, except during the war years. After the war, they resumed regular meetings for their mutual enlightenment and enjoyment.

In this way they cemented old ties. They made new friends, too, and admitted eight of them to their pool. Then they organized formally as The Mutual Investment Club.

Today, the fourteen men who belong to the club have contributed a total of \$18,000. They have also withdrawn a total of about \$10,000. And how much is left? Believe it or not, over \$48,000.

Admittedly, that's a remarkable showing and one not likely to be often duplicated. Tom O'Hara, treasurer of the club and an accountant for Detroit's board of education, admits that luck may play a part in the growth of any given fund; but he insists that the remarkable success of his own group is largely due to its conservative and well-planned investment program.

But more than the money, he says, club members value their increased knowledge of finance and their widened circle of friends.

Obviously, the formation of an investment club is no guarantee of profits. Unwise selections of stocks or bonds will create losses for a club

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just as they will for an individual. Yet the chances are that the more you know about investing the better results you'll get.

Ordinarily, each member of an investment club pays in a fixed amount each month. With this money, the club buys stock.

This brings into play the principle of dollar cost averaging, an important factor in holding down losses. "Dollar cost averaging" means the investment of fixed amounts of money at fixed intervals. When you do this, you automatically acquire more shares when market prices are low and fewer shares when market prices are high.

Probable result, over a cycle of market ups and downs: Your average purchase price during that period will have been less than the average market price.

Clubs Kept Small

The total dollar value of investment clubs is not great. And their profits, with some exceptions, have been modest. But they continue to increase in number.

Membership generally doesn't exceed one or two dozen people. Sometimes, though, a club will include a larger number, especially if it represents an occupational group. One such is the Finest Investment Club, named after New York's "Finest." Patrolman Paul Gross, who started the club, tells me it was built around the prospect that intelligent investment would help its police-force

members supplement their retirement pensions.

Some investment clubs incorporate; some do not. But all of them seem to have a constitution and by-laws. Samples of the latter, incidentally, can be obtained from the Federation of Investment Clubs, 150 Broadway, New York 38, N.Y.

Bob Fisher is an executive of a New York advertising agency. For years, he and Mrs. Fisher have been meeting with a number of other couples for a monthly session of bridge. Some time ago, Bob suggested that they form an investment club, each couple contributing \$20 a month. Thus was born the Bridge Investment Club.

The interesting thing about this group is that the wives take part in it. And they apparently enjoy the investment discussions (which precede the bridge-playing) as much as the husbands do.

But they're not unique in this. For a few clubs even *limit* their membership to women. An example is the WIT Investment Club, made up of female employees of Detroit Edison. The WIT stands for Women's Investment Trust (though one member, proud of their record in picking profitable stocks, says "Women's Intuition Club" might be a more appropriate name).

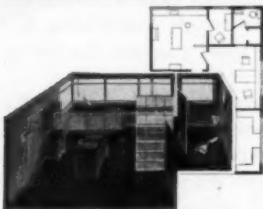
The idea has caught on so well everywhere that I keep hearing about clubs I never knew existed. I recently learned of one in Dallas, for example, that a physician, Albert E.

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Meisenbach Jr., was instrumental in getting started. And some of them even try to "specialize"—like the one at Time magazine, led by sports editor Doug Kennedy, which concentrates on out-and-out speculations.

It's a striking fact, too, that most investment clubs seem to thrive on a sense of humor. Take the names they give themselves, for instance:

One husband-and-wife group is called the Pair-a-Mutual Club. There's another called the 110 Club (original investment, \$110). Others: the Invest 'n' Worry Club; the Sadernwiser Association (get it?); the Euclyptus (you clipped us) Club.

A study made by the Brookings Institution for the New York Stock Exchange has shown that there are only about 6½ million shareholders in the entire U.S. But the invest-

ment clubs may soon help boost this figure by a lot. Through such clubs, the small investor is finding out that by pooling relatively small amounts of money with friends and co-workers, he can learn about capitalism by *being* a capitalist.

Keith Funston, president of the New York Stock Exchange, feels that the clubs may have an even greater value than the promise of education, good fun, and profit. Says he:

"We can preach the virtues of capitalism until we grow blue in the face; but just one stock certificate in the home of Joe Public is a stronger argument than all the oratory of which we are capable. A nation of shareholders is our greatest defense against the foreign 'isms' that would sap our vitality and eventually turn us over to . . . communism." **END**

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Softsoap Opera

By Justin Dorgeloh, M.D.

AUTHOR'S NOTE: Probably most of us disapprove the artificial (always call the patient by his first name), insincere (feign poverty by foregoing Cadillacs), and fantastic (music for the patient's ears, and tea and cakes for his stomach) excesses of some public relations enthusiasts. I would be distressed, however, if the following were misinterpreted as carping at those who have labored earnestly in our behalf to cope with genuine patient-physician problems.

SCENE: *The recently modernized office of A. G. Gotterdammerung, M.D. The soothing decor, conceived by a certified environment-psychologist, includes large paintings of pastoral scenes, innumerable aquariums, and indirect lighting. At the center of the room is a tea cart stocked with goodies approved by a certified food-psychologist. On the walls are framed printed placards exhorting patients to discuss any little misunderstandings with their doctor. Soft music emanates from cleverly disguised high-fidelity loudspeakers; and the cash register has been artfully concealed in a soundproof false-bottom chair.*

DR. GOTTERDAMMERUNG (in ill humor. The tea and cakes he must partake of with each patient have given him indigestion, and the piped-in music is featuring Bach, whom he detests. He addresses his office nurse): What's that racket in the waiting room?

MISS PHIPPS: Why, Dr. G.! You've apparently forgotten that our public relations counsel warned against saying "waiting room." He says it's a psychologically undesirable term.

DR. G. (meekly): I think I hear a disturbance in the reception room. [MORE→]

*This sketch appeared originally in the Bulletin of the Alameda-Contra Costa (Calif.) Medical Association.

Miss P.: You sure do. Some character is trying to chisel his way in without an appointment. (She suddenly flushes.) Pardon me, Doctor. A new patient insists that you see him immediately. He says his trouble is urgent, entitling him to precedence over the others waiting to see you.

Dr. G.: But why the disturbance in the reception room?

Miss P.: He's screaming that he'll turn you in to the newspapers and the Patient-Physician Relations Committee if you callously neglect him one minute longer.

Dr. G.: (paling, and clutching a diathermy stand for support): Show him in, Miss Phipps! The man obviously needs immediate attention!

(Exit Miss PHIPPS. In a moment the outer disturbance ceases, the door opens, and the patient enters. He is MUGGSY BURKE, a burly fellow with an irresistible, good-natured grin. After visiting the tea table to stuff a handful of ladyfingers into his pocket, he sinks into an easy-chair, props his heels upon a Gray's Anatomy conveniently located on Dr. G.'s desk, lights a cigar, and utters a sigh of sheer contentment.)

BURKE: Hi, Doctor!

Dr. G. (jovially): Hello, my good man. Now just tell me your first name, and what's been...

BURKE: Not so fast, Doctor! First let's see your credentials.

Dr. G. (nervously): My diplomas are right there on the wall. [MORE—]



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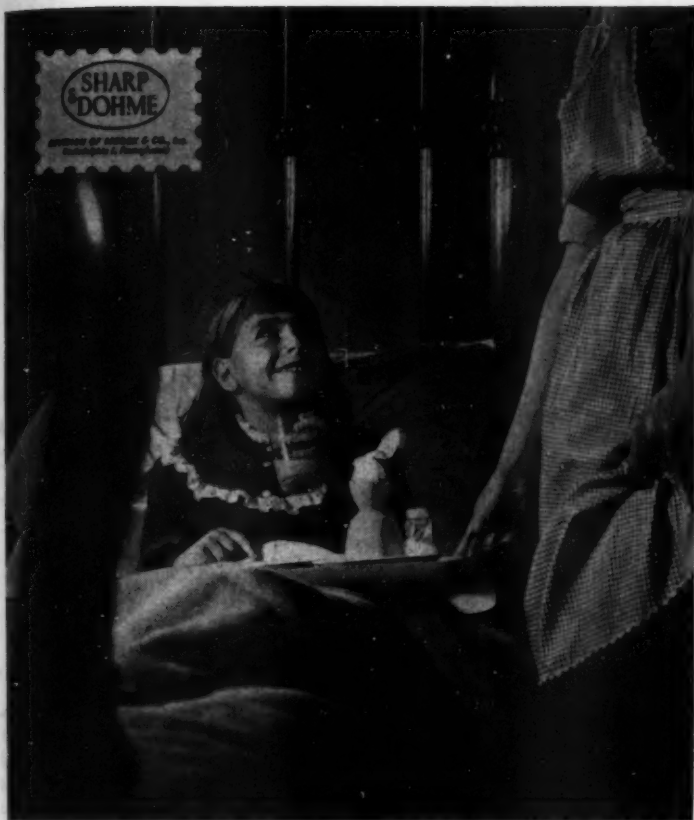
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PHOTOGRAPH BY VICTOR KEPPLER

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(BURKE rises, studies the documents, then returns to his chair after stopping to flick cigar ashes into an Erlenmeyer flask.)

BURKE: How about a college transcript?

DR. G.: College transcript?

BURKE: Sure. Don't tell me you never been to college?

DR. G. (nettled): Of course I have. It's just that it's an unusual request.

(DR. G. searches his desk, finds the transcript, and reluctantly hands it to Burke. The latter inspects the report carefully.)

BURKE (frowning): I don't like this C-minus you got in Biochemistry II, Doctor. How about it?

DR. G. (apologetically): I've tried to make it up by taking post-graduate courses in biochemistry, and . . .

BURKE: O.K., O.K. Now what about a fee schedule? I didn't see none on the wall outside.

DR. G.: Well, each case is a special problem, and . . .

BURKE: Listen, Doctor. I'm not gonna help pay for no yellow Cadillac. Do I get to see that fee schedule or don't I?

(DR. G. sighs. He extracts a card from a file marked "Confidential" and hands it to BURKE, who examines the fee schedule as one would a menu, reading from right to left.)

BURKE: What's a hysterectomy?

DR. G. (wearily): Cutting out the uterus.

BURKE: Oh. Are you one of them guys that does unnecessary hysterectomies?

DR. G. (flushing): Certainly not! I never take out uteri unnecessarily. I only take out unnecessary uteri. I mean . . .

BURKE: Don't get your blood pressure up, Doctor—it's bad public relations. Anyway I don't want no hysterectomy. (He laughs uproariously, obviously pleased with himself.)

DR. G. (coldly): Well, what do you want?

BURKE: Rhinomycin. My nose got stuffy this afternoon, and the Layman's Weekly Review of Medicine tells how fifteen guys took rhinomycin and not a damn one of 'em caught a cold.

DR. G.: Don't you think that I ought to be the one to diagnose your illness and prescribe the treatment you need?

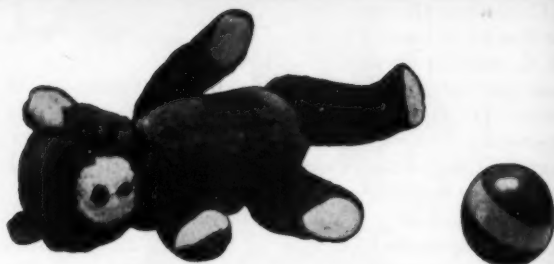
BURKE (becoming angry): Look, Doctor, push the patient around and you'll get socialized medicine. Just hold back on that rhinomycin and let me get pneumonia and you know who'll be in hot water, don't you?

DR. G. (resignedly): Oh, all right. (He writes the prescription.)

BURKE (in good humor again): Thanks, Doctor. Send the bill to Blue Shield, and fix the date up right if you wanta get paid—my policy ran out last month.

(Exit BURKE. As the curtain slowly falls, DR. GOTTERDAMMERUNG is seen silently contemplating the placards posted on the walls, his face enigmatic and thoughtful.)

END




*For greater safety with penicillin
rely on the 'ESKACILLINS'*

Oral penicillin is less prone to cause anaphylactoid reactions than is injectible penicillin.

—Welch et al. of the Food and Drug Administration: Antibiotics & Chemotherapy 3:891 (Sept.) 1953

"With the increase in severity and frequency of allergic reaction to intramuscular injection of penicillin . . . it now appears wiser to administer this drug in effective dosage by mouth."

—Barach, A. L.: Geriatrics 8:423 (Aug.) 1953



for greater safety
for high blood levels
for flexibility of dosage
for palatability
for ease of administration

per teaspoonful



See

Rely on the Eskacillin* line

'ESKACILLIN 50'	50,000 units potassium penicillin G
'ESKACILLIN 100'	100,000 units potassium penicillin G
'ESKACILLIN 250'	250,000 units procaine penicillin G
'ESKACILLIN 500'	500,000 units procaine penicillin G

For combined penicillin-sulfonamide therapy:

'ESKACILLIN 100-SULFAS' 100,000 units potassium penicillin G plus a total of 0.5 Gm. (0.167 Gm. each) of 3 sulfonamides

'ESKACILLIN 250-SULFAS' 250,000 units procaine penicillin G plus a total of 0.5 Gm. (0.167 Gm. each) of 3 sulfonamides

the **'ESKACILLINS'**
are safer penicillins
are effective penicillins

Smith, Kline & French Laboratories, Philadelphia

for iron and nutritional deficiency anemias

here's what your patient gets in

only
3 Iberol
tablets
a day



plus



plus



plus



plus



Equivalent to
THREE FERROUS
SULFATE TABLETS
containing:

Ferrous Sulfate,
U.S.P. ... 1.06 Gm.
(representing 200 mg. of
elemental iron, the ac-
tive ingredient for the
increase of hemoglobin
in the treatment of iron-
deficiency anemia)

Equivalent to
ONE POTENT
& COMPLEX
TABLET
containing:

Thiamine Mono-
nitrate ... 6 mg.
Riboflavin ... 6 mg.
Nicotinamide 30 mg.
Pyridoxine H-Hy-
drochloride ... 3 mg.
Pantothenic
Acid ... 6 mg.

Equivalent to
THREE ASCORBIC
ACID TABLETS
containing:

Ascorbic
Acid ... 150 mg.

Equivalent to
ONE FOLIC ACID
CAPSULE WITH
VITAMIN B₁₂
containing:

Folic Acid ... 3.6 mg.
Vitamin B₁₂ 30 mcg.

Equivalent to
THREE STOMACH-
LIVER DIGEST
CAPSULES
containing:

Stomach-Liver
Digest ... 1.5 Gm.
(containing intrinsic
factor)

prescribe

IBEROL[®]



(Iron, B₁₂, Folic Acid, Stomach-Liver Digest, With Other Vitamins, Abbott)

It Pays to Listen

Let the patient do the talking, advises this physician—since, after all, they're his symptoms!

By John Curran, M.D.

● The woman's remark came back to me indirectly: "I like Dr. Curran, my dear—but wouldn't you think he'd let me do some of the talking?"

That was a long time ago—I've reformed since then—but I was reminded of the incident by a recent magazine cartoon. It showed one of those expansive-looking surgeons with his mouth practically in the ear of an obviously bored patient. The caption read something like this: "So I wrote the President and told him just exactly what I thought of his program."

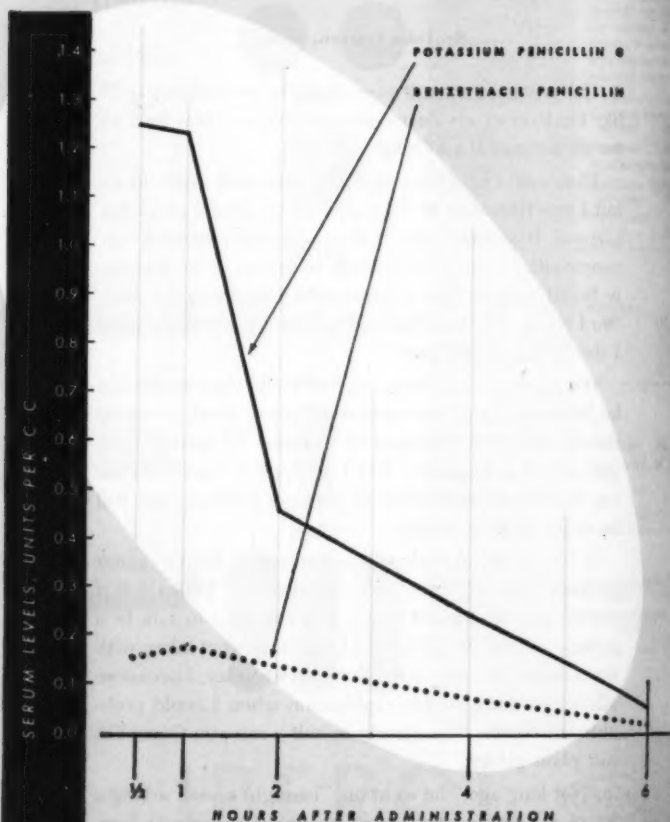
We doctors—some of us anyway—talk when we should be listening. Don't misunderstand me. I don't mean we should affect the demeanor of a sphinx—for taciturnity is just as bad as loquacity. But I do think we medical men can be friendly and solicitous with our patients—and still be economical of words.

A few of my friends in the profession frankly admit prolixity. One of them told me recently: "When I first started practice, I felt that I had the time to talk to a patient as long as I pleased. (I was somewhat taken with the sound of my own voice, too.) Even today, I occasionally give a long, wordy explanation when I could probably convey the idea clearly in half a minute. Guess I'm just plain gabby."

"Not long ago," he went on, "I caught myself asking a lot of inconsequential questions about a patient's fam-

IN ORAL PENICILLIN THERAPY...

Much Higher Initial Peaks
More Prolonged Effective Blood Levels



COMPARISON OF SERUM LEVELS OBTAINED FROM SINGLE ORAL
DOSES OF 300,000 UNITS OF TWO PENICILLIN PREPARATIONS

Adapted from Foltz, E. L., and Schimmel, H. H.

Several very recent studies on penicillin plasma concentration and urinary recovery indicate that potassium penicillin G is the penicillin compound most ideally suited to oral medication.

Following oral administration of the two compounds in equal dosage, Foltz and Schimmel¹ observed a considerably higher initial level and a more prolonged effective serum concentration with potassium penicillin G than with benzethacil.

Boger and co-workers² found no insoluble salt of the antibiotic to be superior to potassium penicillin G.

DRAMCILLIN

Potassium Penicillin G

DRAMCILLIN presents the established effectiveness and safety of pure potassium penicillin G in an unusually palatable form.

A DRAMCILLIN PRODUCT FOR EVERY DOSAGE RANGE:

DRAMCILLIN

100,000 units* per teaspoonful (5 cc.)

DRAMCILLIN-250

250,000 units* per teaspoonful (5 cc.)

DRAMCILLIN-500

500,000 units* per teaspoonful (5 cc.)

DROPICILLIN

50,000 units* per dropperful (0.75 cc.)

Also:

Dramcillin-250 with Triple Sulfonamides

Dramcillin with Triple Sulfonamides

Dramcillin-250 Tablets with Triple Sulfonamides

1. Foltz, E. L., and Schimmel, N. H.: *Antibiotics & Chemotherapy*, 3:593-599 (June) 1953.

2. Boger, W. P.; Bayne, G. M.; Carfagna, S. C. and Gylfe, J.: *Scientific Exhibit*, A.M.A. Convention, New York (June) 1953.

*buffered crystalline penicillin G potassium

WHITE LABORATORIES, INC., KENILWORTH, N. J.

IT PAYS TO LISTEN

ily. On another occasion I diagnosed a heart case—and spent more than twenty minutes bucking up the patient! I could have done it simply by saying, "Tom, your heart's not what it used to be, and it never will be again. But co-operate with me, do as I say, and you'll probably last a long time."

If We Were Rationed

What would happen if we were to be rationed to only a few hundred words a day? We'd soon adopt the habit of getting straight to the point. We'd learn to arrange our thoughts in our minds instead of juggling them on our tongues.

As a result, we'd doubtless be able to see more patients.

A colleague of mine, who handles a practice that would flatten many another good man, learned the trick of oral economy a long time ago. Today, he tells me, he rarely averages more than thirty or forty words to a visit!

Recently, one of his patients—a woman who is perfectly healthy but a chronic complainer—started her usual tale of obscure ailments. The conversation went something like this:

The Chronic Complaint

Patient: "I'm sure I'm going deaf. My throat feels kind of raspy, too, and I really don't sleep as well as I might. My blood pressure must be way up."

[MORE→]

well tolerated; does not predispose
to monilial infection

ILOTYCIN

(ERYTHROMYCIN, LILLY)



the original Erythromycin



It belongs with your trusted
Johnson & Johnson surgical dressings



You'll find the famous Johnson & Johnson quality
in Johnson's Elastic Bandage—Rubber-Reinforced.

Use and prescribe it. You'll like its light weight
and extra elasticity. Women like its *natural* flesh color.

And remember—Johnson & Johnson quality costs
you and your patients no more.

Johnson's ELASTIC BANDAGE
(Rubber-Reinforced)

for COMPLETE PROTECTION you need a WHOLE RAINCOAT



for complete B complex protection
MEJALIN—and only MEJALIN—
supplies all 11 identified
B vitamins plus liver and iron

B complex protection may be needed by the overworked executive with "no time to eat" . . . by that balky youngster that turns up his nose at mealtime . . . by your elderly patient who doesn't like the right foods—in fact, by anyone who eats poorly or sporadically or who requires an extra measure of vitamin support.

Since "vitamins, especially those of the B complex, are closely interrelated" and "lack of availability of any one may affect the metabolism of the others," the importance of a complete B vitamin product is apparent.

Mejalin provides all the identified B vitamins plus liver and iron as an extra safeguard for good nutrition.

Two exceptionally pleasant dosage forms assure patient acceptance.

1. Therapeutic Nutrition, Publication 234, National Research Council, 1952.



One teaspoon of Mejalin Liquid or
one Mejaline Capsule supplies:

Thiamine	1 mg.
Riboflavin	1 mg.
Niacinamide	20 mg.
Pyridoxine hydrochloride	0.2 mg.
Pantothenic acid	1 mg.
Choline	50 mg.
Inositol	20 mg.
Vitamin B ₁₂ (crystalline)	3 mcg.
Folic acid	0.2 mg.
Biotin	0.02 mg.
Para-aminobenzoic acid	0.5 mg.
Liver fraction	500 mg.
Iron (from ferrous sulfate)	7.5 mg.

Mejalin Liquid contains panthemoi and soluble liver fraction N. F.; Mejaline Capsules contain calcium pantothenate and dehydrated liver N. F.

Mejalin Liquid: Bottles of 12 ounces.
Mejaline Capsules: Bottles of 100 and 500.

The complete vitamin B complex supplement

MEAD

MEAD JOHNSON & COMPANY
EVANSVILLE, INDIANA, U.S.A.

Doctor: "M-m-m."

Patient: "I've never felt like this before. Eat like a bird; don't know how such a small amount of food keeps me alive."

Doctor: "M-m-m."

Patient: "Maybe it's my diet; you haven't changed it in months. Do you think I'm going through change of life?"

Doctor (completing examination): "Here—get this prescription filled, and try not to worry. If you don't feel better in two weeks, phone me."

You may be dubious, but this physician's patients think the world of him!

I don't mean to imply, of course,

that every situation can be handled so sparingly. All patients aren't hypochondriacs, and there are times when an extended, "guided" conversation is necessary to elicit required facts. But it's generally best to let the patient do the talking—they're *his* symptoms!

Travelogue but No Rx

Once I let a woman patient get me started telling about my recent trip to Europe. I talked her right to the front door and down the porch steps.

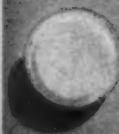
An hour later my telephone rang. "Say," the patient asked, "did I forget my prescription—or did you?"

END

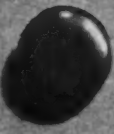


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"Sure, Honey . . . I'll take you down to the office Saturday and give you a few tests."



PABALATE — Each yellow enteric coated tablet contains sodium salicylate U.S.P. 0.3 Gm. (5 gr.), para-aminobenzoic acid (as the sodium salt) 0.3 Gm. (5 gr.), and ascorbic acid 50 mg.



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SALICYLATE • PARA-AMINOBENZOATE • ASCORBIC ACID

REHABILITATION in arthritis

*A clinically effective
therapy that's ex-
traordinarily free
from adverse
reactions . . .*

PABALATE®



PABALATE-SODIUM FREE

Mitigates pain, "round-the-clock"
...and contributes to rehabilitation
by stimulating secretion of cortico-
steroids and prolonging their ac-
tion in reducing tissue reactivity.
Potentiates administered cortisone,
permitting lower dosage.

A. H. ROBINS COMPANY, INC.
RICHMOND 20, VIRGINIA

FREE
steric
moni-
gr.),
as the
5 gr.)

ASCOMBID • in true synergism

XUM

Jottings From A Doctor's Notebook

By Martin O. Cannett, M.D.

● Doctor's Dilemma Department:

An X-ray report on Brennan, A., reads: "Findings characteristic of duodenal ulcer" . . . But Alfred Brennan is a cardiac who has never in his life had a gastric symptom, and hasn't even been sent for a G.I. series. Subsequent clinical research discloses the presence on the gastroenterology service of an Ambrose Brennan, a miserable dyspeptic, with whom the X-ray service has failed to keep its appointment.

The G.I. study was indeed done on our cardiac, and did indeed show a crater in his duodenal cap. And that is the only ulcer the two Brennans have between them. The films of the belching, acidulous, bicarbonate-eating Brennan are negative.

• • •

Delusions of grandeur, taught to every medical student as characteristic of general paresis, are so much rarer in practice than in school lectures that the whole staff flocked to see and hear Daniel LeBlanc. The neurologic findings were clear, but it was his fantastic bragging that we came to listen to. He invited us all to his dude ranch in Montana and we were welcome to stay all summer. His silver mine there was worth \$500,000. And for next winter we must come aboard his yacht and sail the Southern Pacific as his guests.

We walked away with knowing smiles. But it turned out, after a course of malarial therapy, that the ranch and the mine and the yacht were actually real. The only thing

Notable for
SMOOTH ACTION



HALEY'S M-O has long been relied on for smooth, *gentle* action in relieving constipation and accompanying gastric acidity. This pleasant tasting emulsion combines the laxative-antacid properties of Phillips' Milk of Magnesia with the lubricating qualities of pure mineral oil.



Because the minute oil globules are thoroughly distributed and mixed with the contents of the lower bowel, evacuation is bland, soft and thorough. There is no gripping or discomfort and oil leakage is obviated.

Evidence of the demulcent character of Haley's M-O is its frequent professional recommendation when constipation is concurrent with pregnancy or hemorrhoidal conditions.

DOSAGE:

1 to 2 tablespoonfuls before retiring.

THE CHAS. H. PHILLIPS CO. DIVISION of Sterling Drug Inc. 1450 Broadway, New York 18, N.Y.

JOTTINGS FROM A DOCTOR'S NOTEBOOK

that vanished with Mr. LeBlanc's return to sanity was the invitation.

* * *

"Are you a drinking man, Mr. Sooner?"

"Never was, Doctor. Only recently I kind of got started on the stuff, and I can't stay away from it."

"Just how recently is that?"

"Oh, maybe ten, twelve years."

* * *

Fireman Rawlings, who had been caught under the collapsing roof, was found to have an especially precarious fracture of the cervical spine. We all breathed freely when the cast was finally on, with no compression of the spinal cord. That very night, in the course of a nightmare, Rawlings leaped out of bed, twisted

out of his cast, ran through the hall screaming, had to be wrestled back into bed. And nothing happened.

Only two days later the next case of fractured cervical spine was brought in. The patient gave a full history of the automobile accident, and was duly examined. He was not in much pain, had no positive neurologic findings, and there was no spinal deformity. X-ray showed a linear fracture without displacement. Just as the chin halter was about to be put on, the man coughed once, lightly, and was dead.

* * *

Ned Franklin, smoking a cigarette in the academy lobby, has a tale to tell. His father, a long-time sufferer with duodenal ulcer, will have none

81.66%

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M MINUS 5®

Antitensive and Analgesic

1. Lowers excess fluid balance by direct action on the anti-diuretic hormone
2. Reduces stimulus to painful uterine spasm
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Each M-Minus 5 tablet contains:
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DOSE: One tablet 4 times a day, starting 3 to 7 days before expected onset of menses, and continuing through usual period of symptoms.



AVAILABLE in bottles
of 24 and 100
Vander, Milton:
Indus. Med. & Surg.
22:183 (Apr) 1953

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For new Tubex Hypodermic Syringe

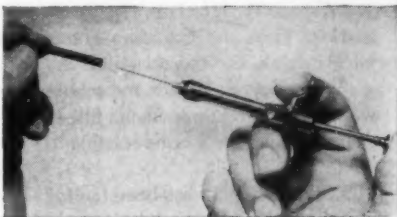
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YOU SIMPLY:

1—load, as easy as
loading your shotgun.
Then close and . . .



2—slip off rubber sleeve,
aspirate and inject!



IN SECONDS . . . ASEPTIC INJECTION

BICILLIN® Injection (long-acting); dibenzylethylenediamine dipenicillin G in aqueous suspension, 600,000 units per TUBEX

BICILLIN® C-R; dibenzylethylenediamine dipenicillin G, 300,000 units and procaine penicillin, 300,000 units in aqueous suspension, TUBEX of 1 cc.

DIHYDROSTREPTOMYCIN SULFATE; crystalline solution, 0.5 Gm.

LENTOPEN®; procaine penicillin G in oil with aluminum monostearate, 300,000 units per TUBEX

LENTOPEN®, All-Purpose; procaine penicillin and potassium penicillin in

oil, 400,000 units per TUBEX

WYCILLIN® Suspension; procaine penicillin G in aqueous suspension, 300,000 units per TUBEX

WYCILLIN® 600 Suspension; procaine penicillin G in aqueous suspension, 600,000 units per TUBEX

SUPPLIED IN BOXES OF 10 TUBEX



Philadelphia 2, Pa.

JOTTINGS FROM A DOCTOR'S NOTEBOOK

of his medicines made up at the drugstore. He takes only the samples Ned gets from detail men.

Why?

Why indeed! It's simple. No company would send samples to physicians without taking good care to offer only their finest drugs . . .

My talk to the parents' group was on "Calories and the Diet." Followed the discussion period and questions:

"Doctor, how can I make my Shirley eat her cereal?"

"Why is it, Doctor, the more crackers I eat and the more grape-juice I drink, the more I gain?"

"What do you think's the matter with my daughter? She's fifteen years old and she sweats terrible."

Mrs. Ellis for years has been feeling herself all over for the faintest indications of oncoming cancer. Mr. Ellis is a stolid citizen, immune to hypochondriasis.

Yet witness the capriciousness of Fate:

Last week the husband presents himself to me with an ulceration. The biopsy report shows—of all things—carcinoma of the breast.

Two years ago Phil Swinton instituted suit for compensation following a groin injury, claiming loss of procreative power. With nine children already in the fold, it did not seem at the beginning as if he had much of a case in court. Phil himself took the view that this was added

indication he had had something to lose.

The law's delays have hit Phil a body blow. Three days ago he became the sheepish papa of No. 10.

The middle-aged female who had come in for a check-up was a new experience for interne Seeley. She combined an unpleasantly overbearing manner with odd stories of a Yogi novitiate.

"Young man," she told him, "I wish to show you my own modifications of Yogi exercises. I am going into a period of suspended animation, and I want you to test my reactions during this time."

As a first investigation, Seeley decided to test the patient's spiritual discipline with a dose of salts. The seance was abruptly suspended . . .

The behavior of Noah Searles was not consistent with any known type of diabetic perversity. A check-up revealed that the fault was not in him but in his practical nurse, who administered the insulin by carefully withdrawing the prescribed unitage in the syringe, squirting it into the orange juice, and giving the mixture to the patient to drink.

For an old campaigner, Dr. Savitt left himself rashly open at the pathological conference. He spent ten minutes castigating pathologist Prah! for hedging on the differential diagnosis between Hodgkin's disease and lymphoblastoma. [MORE→]

Up stood Prahl, sad of mien as ever. "As I said before, gentlemen, in this case even the autopsy leaves us in doubt. Dr. Savitt's surprise at my failings is a welcome compliment. I have done worse than this in my time. Heaven help me, I've called some appendices removed by Dr. Savitt chronic appendicitis."

* * *

The first announcement card breathed the elaborate severity, the withdrawn other-worldliness of the undertaking brotherhood. A month later, a Christmas card followed, gorgeous with flowers on snow and angels of remarkable wingspread.

It was only this week that I found myself walking past the establishment, and belatedly stopped in to acknowledge the courtesy.

"Oh, that's all right, Doctor. Us professionals got to stick together. We want you to like us."

I almost caught myself promising I would do what I could for him.

* * *

A conviction which began to nestle in our mind during internship days has grown with the years: Nineteenths of the family-history data that goes on millions of charts is of no discernible good to anyone. Take Mr. Fiscall, decrepit, toothless, bleary-eyed dodderer:

"My father? Say, he was 94 when he died. Commissioner of Roads. They elected him on his 94th birthday. Looked more like 54. Had all his hair and all his teeth. What did he die of? Foolishness, that's what.

Went out in the snow, caught cold and died. Sure wish't I had his teeth."

* * *

A medical publication carries an offer of free recordings to doctors interested in learning how their voice sounds to others. This should relieve those colleagues who are eager to sound their very best when Mrs. Wimple calls up for the fourth time to ask, "Does the formula call for twenty-four ounces of milk? Or is it twenty-four ounces of Karo syrup?"

* * *

The high-caloric diet Dr. Linden orders for his ward patients is superfluous. Their gain in weight is not so much a matter of special diet as of the sugar coating on all the pills they swallow.

END



"I said, 'Keep him in bed at least another day, Mrs. Grummel' . . . Are you there, Mrs. Grummel?"



For every patient
with clearcut menopausal
symptoms such as **hot flushes**,
there's another patient with symptoms less clearly defined
yet just as distressing . . . headaches,
insomnia, mental and physical fatigue.

Her symptoms may also be indicative of declining ovarian function, and occur
several years before, and even long after, menstruation ceases.

This patient, too, may be expected to **benefit** from "Premarin" therapy.

"PREMARIN" is a complete equine estrogen-complex.

It not only produces prompt symptomatic relief, but also imparts
a distinctive "**sense of well-being**"
highly gratifying to the patient. It is tasteless and odorless.

"Premarin," estrogenic substances (water-soluble),
also known as conjugated estrogens
(equine), is supplied in tablet
and liquid form.



A Lawyer Prescribes A Cure for Ghost Surgery

Are doctors ill advised in wanting medicine to discipline its own? Here's a thought-provoking argument for giving wrongdoers over to the law

By Oliver K. King

● Where there's a wrong there's a remedy. This is a juridical maxim. All too often we hear the layman exclaim, "There ought to be a law." Ninety-nine times out of a hundred there is one—if somebody only takes the trouble to look it up.

Fee splitting among doctors is definitely illegal in many states. In New York, for instance, the law reads in part as follows:

"The license or registration of a practitioner of medicine . . . may be revoked, suspended or annulled [if he] has directly or indirectly requested, received or participated in the division, transference, assignment, rebate, splitting or refunding of a fee . . ."

No such law applies to lawyers. In the legal profession it's considered ethical to split fees—because we think it unwise to tempt the inexperienced lawyer into trying a case that's "over his head." To avoid such courtroom butchery, we permit him to retain competent trial counsel and still be entitled to a share of the fee. [MORE→]

JUDGE KING is legal chairman of the Westchester (County, N.Y.) Committee on Medico-Legal Relations. His article is appearing also in the *Westchester Medical Bulletin*.

Pyribenzamine® Expectorant *with Codeine*

Ciba

products of performance



*for
unproductive
and difficult
coughs*



THE PATIENT FEELS

a rapid end of "tickling" and irritation, of unproductive coughing and difficult coughs—soothing.

YOU OBSERVE

a readier clearing of the bronchi with minimal effort and less fatigue.

THE FORMULA

Each 4 ml. teaspoonful contains:

30 mg. *Pyribenzamine citrate*
(tripelennamine citrate Ciba)

8 mg. *codeine phosphate*

10 mg. *ephedrine sulfate*

80 mg. *ammonium chloride*

A successful approach to cough control via liquefying, antihistaminic, spasmolytic and inhibitory actions. Also available without codeine.

Ciba Summit, N. J.

af 10008

There are certain qualifying circumstances, of course:

1. Such a procedure should not cost the client more money.
2. The client should (*must*, usually) know about it.
3. The "forwarding attorney" should contribute some work to the case.

We also recognize that a tax problem requires a tax expert; an admiralty matter prompts the consultation of a proctor; and a patent problem can be handled only by a patent lawyer.

Too, we often find that a contract, a will, or other instrument should be in such form as to be enforceable in another jurisdiction. This requires retention of, and consultation with, counsel of such other jurisdiction.

Medicine Is Different

In this respect, a medical expert has an advantage over a legal expert. A doctor who is qualified in any state as, say, a urologist is so qualified throughout the world, since the human body is the same in Astoria, Australia, and Albania.

But a lawyer in New York has only to travel a few miles westward (to New Jersey) or eastward (to Connecticut) to find that he's not a lawyer at all, and that the attainments acquired by years of study are nullified. He can only appear in court by special permission and under the sponsorship of local counsel.

So fee splitting among lawyers is a necessary practice. Some doctors,

I know, would contend that it's equally desirable in their profession. Conceivably, for example, the prohibition against it might cause a doctor with limited qualifications to perform surgery when, except for the economic problem, he'd prefer to advise the employment of a more highly qualified man.

But this is an academic question—in a number of states, at least. Where fee splitting is illegal, there's little point in discussing its desirability.

Ghost Surgery Scored

Ghost surgery, however, is a horse of another color. There's no justification whatever for it. It reeks of fraud.

Do I hear, "There ought to be a law"? There is. And an offense like ghost surgery should be easy to detect—and to punish. Any misconduct that requires the complicity or acquiescence of others won't likely be committed if penalties are swift and severe.

Anti-fee-splitting laws are one weapon against the "ghosts." If fee splitting is illegal, then, ipso facto, so is ghost surgery. Obviously, there would be no ghost surgery if the fee couldn't be split.

But there's another kind of law, with more teeth in it, that ought to be invoked: Ghost surgery is an assault—a criminal assault—not only by the surgeon but by the anesthetist as well, if the anesthetist knows that the surgeon is a "ghost." An in-

Physiological test compares

Kent's "Micronite" Fi

TO COMPARE the efficiency of various filters as they affect physiological responses in the cigarette



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smoker, drop in surface skin temperature at the last phalanx was measured.

Using well-established procedures, the subject smoked conventional filter cigarettes and the new KENT with the exclusive Micronite Filter.

For every other filter cigarette, the drop in temperature averaged over 6 degrees. For KENT's Micronite Filter, there was no appreciable drop.

These findings confirm the results of other scientific measurements that show these facts: 1) KENT's Micronite Filter takes out *far more* nicotine and tars than any other cigarette, *old or new*. 2) Ordinary cotton, cellulose or crepe paper filters remove a small but ineffective amount of nicotine and tars.

Thus KENT, with the first filter that really works, gives the one smoker out of every three who is

susceptible to nicotine and tars the protection he needs . . . while offering the satisfaction he expects of fine tobacco.

For these reasons, smokers have made the new KENT the most popular new brand of cigarette to be introduced in the last 20 years.

If you have yet to try the new KENT, may we suggest you do so soon?



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GHOST SURGERY

terne or nurse assisting at the operation would also be guilty if aware of the facts.

What Kind of Assault?

In my opinion, ghost surgery is second-degree assault—a felony. Upon conviction (in states like New York), this would require a revocation of the offending doctor's license. Even if deemed a third-degree assault, such surgery would still be a crime for which the state could revoke the doctor's license.

A great jurist, Benjamin Cardozo, once expounded the basic principle as follows:

"In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault."

(Of course, the law in its wisdom recognizes that, in emergencies, consent can't always be obtained. But let's not discuss emergencies in this context.)

Incident in a Hospital

A recent issue of The Saturday Evening Post carried an article by Steven M. Spencer, entitled "Patients for Sale." Let me quote a passage from the article (which, by the way, was accompanied by an approving foreword from Dr. Paul H. Hawley, director of the American College of Surgeons):



"Doctors Agree"

Last week I found a spool of Pro-Cap plaster in a dish I hadn't touched in over three years. I used it. It stuck.

I've thrown away many a roll of tape—they dry out too fast. Pro-Cap stays fresh and tacky longer.

I'm very satisfied with Pro-Cap. It seems to have a longer life than other plasters.



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We use three or four brands of plaster in my hospital. The Supply Dept. often asks us to take "X" or "Y" brand if they have a heavy inventory. Pro-Cap seems to keep its tack longer.

We use three brands of plaster in my hospital. I like Pro-Cap, because even if you get an old roll, it's a fresh roll.



"Dealers Confirm"

I handled four brands of tape for years. I was getting complaints about lack of tack and drying out. Now I carry Seamless Pro-Cap and no complaints.

One of my stock boys neglected to rotate some Pro-Cap six months ago. I was going to try to send it back. Then I tried it. It was still fresh and tacky.

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GHOST SURGERY

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"Why, he didn't operate on you," said the mother superior. 'Doctor X did.'

"Well, for goodness sake, who is Doctor X?" the astonished patient asked. 'I've never even heard of him.'

"The mother superior's suspicions of ghost surgery thus confirmed, she summoned the 'ghost,' who offered no defense and was therefore promptly fired from the staff. He was also expelled, after a hearing, from the College of Surgeons."

(Why in Heaven's name didn't she telephone the office of the District Attorney?)

M.D.s' Self-Discipline

The foregoing seems to epitomize the discipline of the medical profession over itself. Expulsion from medical societies or disbarment from use of hospitals is the weapon used.

But is this enough?

Why not kick the scrubs entirely out of the profession? Why not revoke their licenses?

I have asked these questions of

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A CURE FOR GHOST SURGERY

doctors many times. The usual answer is, "When we try to punish physicians in this manner, they hire a member of your profession (a lawyer) and advance a sob story that they're being deprived of the means of earning a livelihood."

So what? The accused is entitled to counsel and to a fair hearing.

The same sob story is advanced by counsel for every lawyer involved in disciplinary proceedings. Admittedly, a disbarment or a suspension deprives the offender of earning a professional living. So does imprisonment. The real question is *whether or not he is guilty*. If he is, he should pay the penalty.

The greatest value to society in these matters is the deterring ele-

ment. The medical profession ignores this principle, primarily because it tries to be a law unto itself. And in this capacity it has failed.

The bar falls far short of weeding out *all* offenders. Every lawyer will admit that. Sympathy, special influence, and other improper factors keep many lawyers licensed who ought to be disbarred or suspended. But at least we *try*.

All disciplinary actions (and there are hundreds each year) are conducted by members of our own profession—through grievance committees at first, and then in the courts. We don't achieve perfection, but—I repeat—we *try*.

Why doesn't medicine make the same effort? You can't, I insist, weed

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Ascorbic Acid (as Sodium Ascorbate).....	100 mg.
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Vitamin A Synthetic.....	10,000 units
Vitamin D Synthetic.....	1,000 units

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¹ Barron, A. L.: Management of Cough in Daily Practice. JAMA, 148:501, Feb. 16, 1932.

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A CURE FOR GHOST SURGERY

out offenders just by publicly approving magazine articles that expose those offenders. On the contrary, such gestures seem to me deplorable. Articles on malpractice not only publicize the iniquities; what is far worse, they advertise the helplessness of the profession in trying to clean its own house.

In his foreword to the Saturday Evening Post article, Dr. Hawley made the following rather astonishing statement:

"The expediency of informing the public that some doctors practice unethically has been seriously challenged. The American College of Surgeons believes not only that people have the right to this information but also that little improvement may be expected without their help."

When Dr. Hawley states the need for public help, it seems to me that he indicts the entire medical profession. However, I'll take him at his word. As a member of the public to which he refers, I'm willing to "help" by pointing out one way in which these evils can be corrected.

Any surgical procedure is assault—assault with a deadly weapon—*except with the consent of the patient* (or of the parents, if the patient is an infant). It's true, as I've pointed out, that in emergencies, when actual consent is unobtainable, it may be implied. But if consent has been obtained by fraud, it isn't consent at all.

The ghost surgeon lacks consent entirely. The patient has never seen

him, never met him, never heard of him. Hence the attack upon the patient's body by the "ghost" is an assault—a criminal assault.

"But," said a medical friend recently, "what happens when the surgeon is himself stricken ill in the course of an operation and unable to continue? If some other competent man steps in to finish the job, is he guilty of assault because he lacks the consent of the patient?"

My reply: "Don't be silly."

The consent of the unconscious patient would be implied in any such emergency, just as it would if the surgeon were to encounter an unanticipated condition in the patient's interior with which he wasn't qualified to cope. In this event, he of course could (and should) ask the chief or any other qualified man available to take over.

Court Action Advised

But there is no emergency in ghost surgery. So why don't doctors take such cases to court, where they belong? Why do physicians generally seem to distrust the courts?

I think their distrust stems largely from ignorance. And I suggest they read the reported opinions of the courts in a couple of dozen selected cases involving surgical assaults, malpractice, narcotics, abortions, and other subjects in which the medical and legal professions have become entangled over the years.

Any doctor who does so will, I know, be impressed by the evidence

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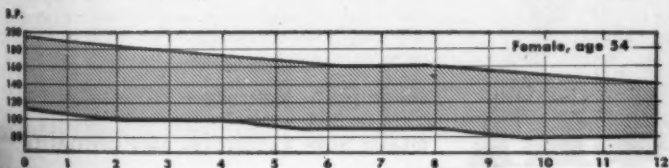
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Weeks of therapy. Rautensin, 4 mg. daily. Marked subjective improvement.

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A CURE FOR GHOST SURGERY

of understanding and respect for the medical profession on the part of judges.

But I wouldn't recommend such a course of reading for the ghost surgeon. Or—on reflection—maybe I would. He would find no comfort in it; but he might, none the less, be benefited. He might be inspired to "go and sin no more." Or he might learn to know fear—fear of the law that he habitually violates.

Some doctors may believe that only the patient has a legal right to complain of ghost surgery. This is not true. Any citizen may report the commission of a crime to the legal authorities and may give sworn testimony of his knowledge. Indeed, he *should* do this.

A hospital superintendent, a doctor, a nurse, or an orderly who has knowledge of the facts is obligated to report them. Failure to do so (especially on the part of the executive of the hospital) is, quite simply, compounding a felony.

Of course, there may be certain practical difficulties. If Dr. X, a ghost surgeon, knows his activities have been detected and reported, he'll probably swing into action. Doubtless, he and his fee-splitting accomplice will beat a path instantly to the doorstep of the patient and will try to make a deal.

If the patient can be persuaded to repudiate his original statement as to nonconsent, there can be no case, obviously. And this may easily hap-



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Herrold, R. D.: Surg. Clin. North America 30:61, 1950.

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pen—especially if the surgery was successful and the two miscreants have agreed to waive all charges for their service.

Suppose, then, that Dr. X and his G.P. partner in crime do escape the talons of the law. Isn't it fair to assume that they'll have been thoroughly scared by the experience? Won't the fright and mental anguish suffered deter them, and others of

their ilk, from repeating such adventures in the future?

If you *really* want to stop ghost surgery and fee splitting, quit being namby-pamby about it. Put fear—fear of exposure, conviction, and revocation of license—into the offenders.

The law and the machinery for its enforcement are at hand. Use them.

END

Two New Books Discuss The Economics of Medicine

By Nelson S. Page

● "Paying for Medical Care in the United States," by Oscar N. Serbein Jr., PH.D. (Columbia University Press; \$7) and "Doctors, People, and Government," by James Howard Means, M.D. (Little, Brown and Company; \$3.50) are a couple of recent volumes that most private physicians may not want to read from cover to cover. But both books are certainly worth looking into.

Of the two, the Serbein volume probably merits the more serious consideration. While it contains almost nothing new, it brings together in one place a great deal of existing data and may thus serve a useful purpose as a reference source. It should be of interest chiefly to medical societies, hospitals, medical schools, and individual practitioners who do a volume of writing or speaking on the economics of medicine.

Dr. Means' book is a very different matter. It, too, compresses between two covers quite a bit of familiar mater-

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ial on the fiscal, social, and political aspects of medicine. But it lacks the saving grace of the Serbein book; for it doesn't even qualify as a reference work. Its most useful purpose would seem to be as a text for indoctrinating potential members of such left-leaning organizations as the Committee for the Nation's Health. Both the physician and the informed layman will quickly recognize Dr. Means' text for what it is: a rehash of all the old arguments against independent medical practice.

'Paying for Medical Care'

The nearly 500 pages of "Paying for Medical Care in the United States" stem from a study Dr. Serbein* made for (and as a faculty member of) Columbia University, under a grant from the drug-industry-financed Health Information Foundation. The book is a broad-scale review of all the methods now being used in this country to pay for medical care. Of special interest are the chapters on illness costs, prepayment plans, and governmental programs.

The scope of the research was so defined as not to demand the gathering of any new data. Yet there were problems involved even in gathering existing data. For example:

Information on the money paid by industry and government to physicians was "highly incomplete,"

*OSCAR N. SERBEIN, PH.D., is assistant professor of statistics at the Graduate School of Business, Columbia University.

says the author. Data on salary payments to physicians were "inadequate," too.

Some of the figures on consumer expenditures for medical care were "usable only with reservations." And Dr. Serbein's attempts to get material on the costs of illness were, as he puts it, "slowed down or thwarted by all sorts of factors."

Among them: duplication of enrollment in prepayment plans; conflicting financial estimates; the lack of a sound means of determining outlays for medical care made by industry, government, etc.

On Prepay Plans

Since he and his research staff apparently devoted more of their attention to prepayment plans than to anything else, and since these plans get the lions' share of space in his book, the reader may well ask: What do these people think about prepayment plans after all their study? And what do they see as the major problems facing such plans?

Dr. Serbein summarizes the strength of medical care plans as follows:

Insurance is "a practical way of prepaying a large part of medical costs." In fact, insurance goes "beyond financial protection by encouraging better utilization of medical services . . . improvement of the quality of medical care, and . . . prevention and early diagnosis of disease.

"More than half the population of

BOOKS DISCUSS ECONOMICS OF MEDICINE

the United States now have some type of medical care prepayment coverage. [It] is available to all social and economic classes . . .

"The insurance mechanism is flexible, and a wide variety of contracts have been developed to take regional differences into account. Costs are still moderate in spite of the great increase in the cost of medical care."

Their Drawbacks

Dr. Serbein then summarizes the prepayment plans' weaknesses:

They "exhibit considerable variability in the extent of their protection. Only a few . . . provide preventive and diagnostic services. Generally, illnesses such as tuberculosis

and mental disease are excluded from coverage . . . There is often no protection against a financial catastrophe caused by illness requiring prolonged medical care . . .

"Prepayment plans generally do not afford adequate protection for high-income groups who take private hospital accommodations and whose bills for medical services are apt to be large. Cash payment plans written on an individual basis often pay a comparatively small part of the insured's medical bill . . .

"Exclusions and limitations contained in insurance contracts restrict their usefulness . . .

"Some types of contracts, especially those that provide cash for physicians' services, may encourage

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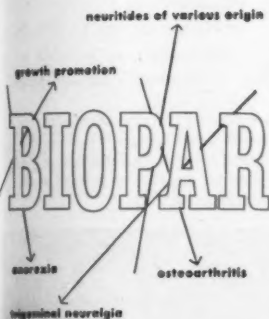
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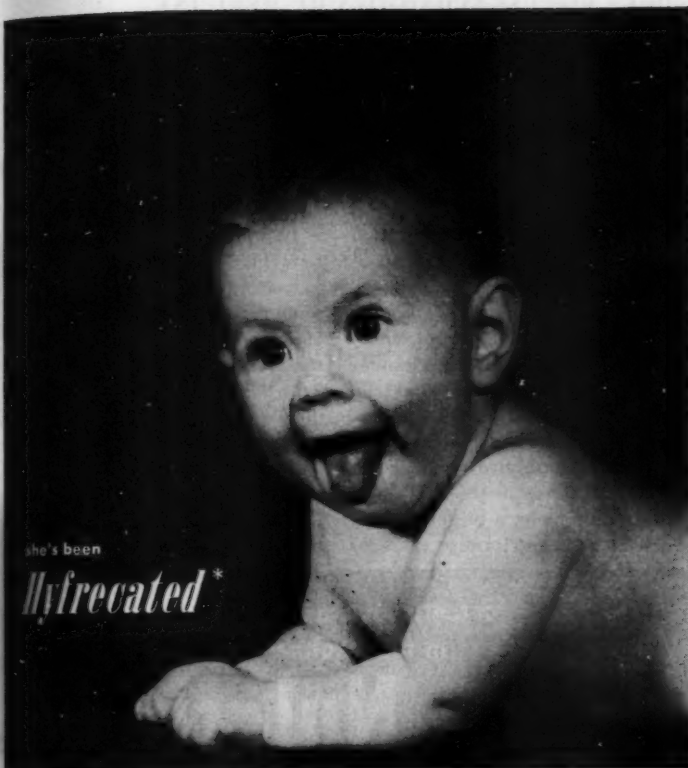
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charges by some physicians that are higher than usual. The cost of prepayment plans is such that low-income people cannot afford them . . .

"There are too many different types of organizations selling medical care protection. Amalgamation in many areas seems desirable . . .

"Most medical care insurance contracts are written without a deductible. This means that insurers must handle a large number of small claims with attendant high administrative expense. There would be no such problem if most persons would budget for small medical bills and reserve insurance for expenses of financial consequence."

The author sees a bright spot on the horizon in the form of catastro-

phic coverage. This, he says, offers real advantages to those persons whose medical charges are likely to be high because of long-term illness.

'Economic' Catastrophe

In a footnote, he adds this thought: "The use of the expression 'catastrophic illness' has caused some confusion in the past because of the tendency to use it as a medical term relating to some type of illness. This tendency is unfortunate, since illnesses are ordinarily classified as acute or chronic and either classification may include illnesses that are catastrophic in a financial sense.

"A catastrophic illness may be defined as any illness, acute or chronic,

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** Steigmann, F., and Goldberg, E., J. Lab. & Clin. Med. 42:63, 1953.

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the financial impact of which seriously disrupts the family budget.

"Thus, a catastrophic illness is strictly an economic phenomenon. Whether or not an illness is catastrophic for a particular family or individual depends primarily on income but also on the amount of savings and other financial resources of the patient. It also depends on whether the ill person is responsible for the income of the household or whether he is dependent on someone else for a livelihood . . .

"In view of these facts it is impossible to state categorically that a bill amounting to x dollars per unit of time is catastrophic in its effect. Probably for people in the income range of \$3,500 to \$5,000, a \$2,000 medical bill in any one year would be catastrophic; but the other financial resources of the individual would have to be known before a definite decision could be made."

What of the Future?

In addressing himself to the main issues that now confront voluntary health insurance, Dr. Serbein says:

"Perhaps the chief problem facing prepayment plans, other than that of increasing enrollment, is the problem of the extension of benefits to include illness now excluded or . . . restricted. The possibilities of extension are complicated by the increased costs of medical care and necessary increases in the selling price of insurance, as well as by widespread belief in the 'uninsur-

bility' of certain types of illness."

Other major problems are set forth by the author in the form of questions. Among them:

1. "Should insurance be concerned only with medical bills that represent a real financial burden?"

His answer, in effect: Yes. "It is a generally accepted principle in other lines of insurance that small claims result in high administrative cost and should be avoided through the use of a deductible." If this principle were adopted, he says, more could be done to assure adequate benefits.

Not Just Financial

2. "To what extent should medical care insurance be looked upon as a financial arrangement only?"

It should not, he believes, be so regarded. "Experience . . . indicates that it is difficult to provide adequate benefits unless some type of cooperation exists between the plan and the medical profession." The most comprehensive plans in operation today, he says, are those that have enlisted such cooperation.

3. "Is insurance necessary for persons with high incomes?"

The answer here seems to be, "We don't know." It is often alleged, says Dr. Serbein, "that persons earning over, say, \$8,000 per annum do not need insurance . . . How true or false this statement may be has never been tested by a consumer survey." The issue is complicated, he adds, by the fact that charges by

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physicians tend to be higher for high income groups, as well as by other factors that influence the net financial position of persons of better than-average means.

4. "Is comprehensiveness the goal?"

Whether it is or not, the author says, "many citizens prefer a prepayment plan that pays for the complete range of scientific medicine. There is concrete evidence that labor unions and other organizations are demanding coverage for payment for complete care and not for just a part of the bill. This desire for comprehensiveness is one of the major challenges facing present-day prepayment plans."

* * *

'Doctors and Government'

"Doctors, People, and Government" and its author, Dr. Means, are described as "courageous" by Dr. Michael M. Davis, executive committee chairman of the Committee for the Nation's Health. "Dr. Means," he says, "does not come out in favor of national health insurance but expresses his hope that through step-by-step methods we can attain the goal . . ."

Author Means himself says he places nationalized medicine "at the present time in the unattainable category." Under the circumstances, he

* James Howard Means, until his retirement a couple of years ago, was for twenty-eight years clinical professor of medicine at the Harvard Medical School and chief of the medical service at the Massachusetts General Hospital. He is a former president (1938) of the American College of Physicians.

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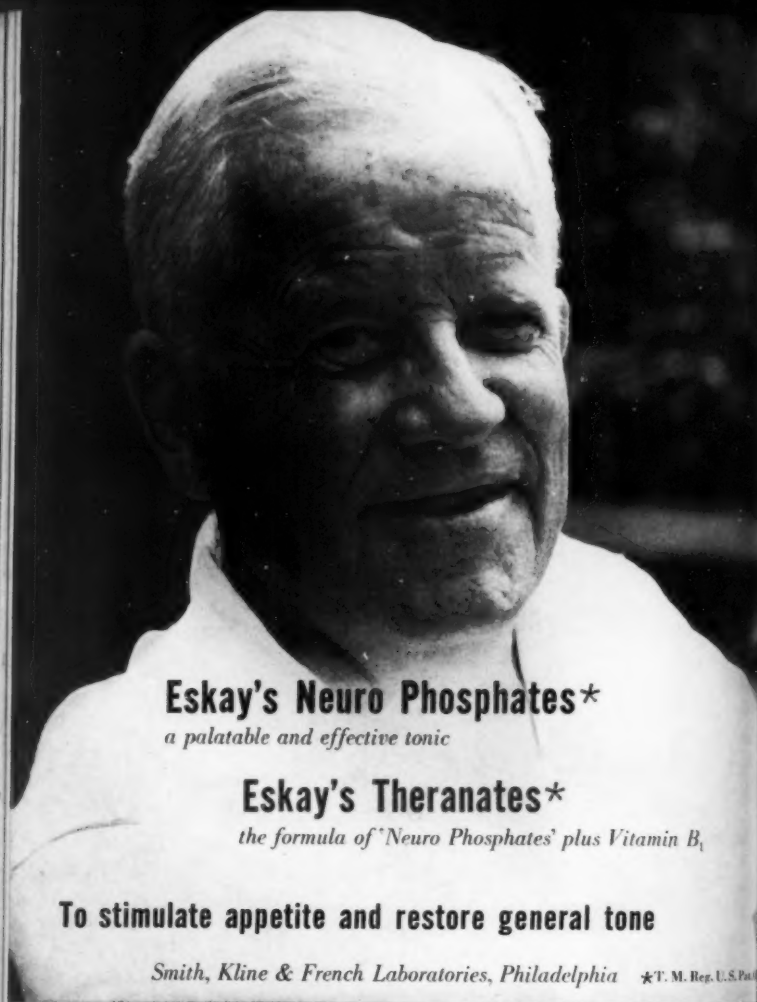
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concludes, "perhaps we had better pin more hope on spontaneous local endeavor."

As long as we do not have nationalized medicine, Dr. Means believes that "prepayment plans which afford benefits directly in the form of comprehensive service are today the method of choice . . . Payment for medical care on a fee-for-service . . . basis is outmoded."

Likes Panel Plans ?

Doctors, he says, ought to practice in groups and they should be paid "by salary . . . or by salary plus a share of [group] earnings."

Each university hospital, he maintains, should serve the function of a medical center, joining together "a medical school, a teaching hospital, a comprehensive prepayment plan, a home care plan, and an organization of doctors for group practice on a salaried basis. Preventive services should be provided as well as curative."

Government support, Dr. Means says, should be given each such medical center on a grant-in-aid basis. For "government aid to both education and research is indispensable."

The great challenge to the American people in the field of health, he maintains, is to "unify voluntary effort with government effort." Using Britain's National Health Service as an example, he points out that "the British divided the country into regions, each based on a university medical school. The medical school



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*Swartz & Reilly, "Diagnosis and Treatment of Skin Diseases", p. 66.

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they made the heart or focal point of each regional unit of the health service. In this they showed great wisdom, for . . . the medical school is the fountainhead of medicine. I favor doing essentially as the British have done . . ."

Schools as Focus

There are seventy-two four-year medical schools in the United States. And Dr. Means recommends "the development of a local health plan based on every one of them:

"Take for example the Massachusetts General Hospital . . . Although an institution independent of the University, it is nevertheless a teaching clinic of Harvard. It segregates its patients into three categories—

public, semi-private and private. The public ward patients have a better chance of getting good medical care than either of the other groups. This is because they are cared for by closely knit teams of doctors always on the spot and ready to mobilize resources faster than can be done in either of the private pavilions.

"In my opinion, the full private pavilion is the least desirable from the medical care point of view. The patients there are attended largely by individual practitioners, who may or may not call in all the consulting skill which would invariably be sought in the public areas. Another point of great importance is that in the public areas medical stu-

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REFERENCES:

1. Palmer, J.H., and Ramsey, C.G.: *Canadian M.A.J.*, 65:16, July, 1951; P. Dailheu-Geoffroy: *La Clinique*, 46:27, May 1951.
2. Melville, K.I., and Lu, F.C.: *Canadian M.A.J.*, 65:11, 1951.
3. Pfeiffer, H.: *Klin. Wochenschr.*, 28:304, 1950.

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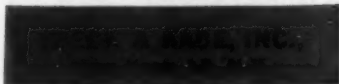
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BOOKS ON ECONOMICS

dents participate actively in the care of patients . . . I firmly believe that the presence of students improves the quality of medical care.

Wants 'Equality'

"To generalize then: The poor, collectively at least, get the best care and the least luxury; while in the case of the rich, it can be just the reverse.

"I should like to see all these segregations wiped out. I should like to see all patients get equality of care. The wealthier ones could continue to have more luxurious quarters provided they got the same quality of medical care. I would like every patient, regardless of economic status, made available for teaching. Medically at least this would be to every patient's advantage.

"To this end it would be necessary to make a tight-knit practice group of the entire staff. This would have to be subdivided into smaller groups for actual medical care . . . The doctors in such a scheme, in my opinion, would best be placed on salary and the patients in prepayment plans which pay for comprehensive medical care in service, not cash. Those patients who could not pay all or any of the premiums would have to have them paid, as always in the case of the poor, by government or by charity.

"In brief, then, if a teaching hospital like the Massachusetts General were united with a medical care plan like H.I.P. in New York, together with an adequate Blue Cross,

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From where I sit by Joe Marsh



Wish I'd Said That

You know Miss Perkins. Well, she's been driving her own car around our town for a little more than 30 years.

The other day she had a little bit of trouble parking down on Main Street. Didn't quite make it the first try, so she pulled out to start over when a young fellow waiting to pass started tooting his horn impatiently.

On the second try, she was still having difficulty, so this smart aleck behind her hollered, "Lady, do you know how to drive?" "Yes, young man," Miss Perkins answered, "I do. But I don't have time to teach you right now."

From where I sit, it's not always easy to have a good answer ready just when you need it. But when somebody tells me how to practice my profession, for instance, or to choose tea instead of a temperate glass of beer I like with dinner, I know the answer. We all have a right to our own ideas . . . and none of us like "backseat driving" from anybody.

Joe Marsh

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BOOKS ON ECONOMICS

if it found ways and means to pay the premiums of those who could not afford to do so themselves, and if it placed all its doctors on salary and made all its patients available for teaching, it would be reaching the ideal . . ."

"There would be smaller community hospitals affiliated to the central one in various ways, such as exchange of professional staff or the forwarding of patients as their own required facilities or special skills only available at the center."

Planning Needs

"The prospects for national planning, and the actual setting in motion of a health program by voluntary effort at the national level, are not bright at the present moment," Dr. Means feels. "Neither government nor private enterprise can do the job alone, and they cannot cooperate with one another with complete effectiveness until each itself becomes better integrated."

So the author advocates the establishment of a permanent health commission with broad lay and professional representation. Such a commission, he thinks, could be set up by Congress, with similar bodies in states and local communities.

The health commission, he says, would be purely advisory, but it would be "of great service in health planning." Of the members of the commission, "not more than half . . . should be health professionals."

He adds:

"Because of the generous inclu-

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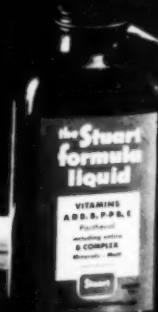
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Calcium	213 mg.
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Vitamin B ₁₂	5 mcg.
Niacinamide	100 mg.
Ascorbic Acid	125 mg.
Calcium	100 mg.
Cobalt	0.1 mg.
Copper	1 mg.
Iodine	0.15 mg.
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Magnesium	6 mg.
Manganese	1 mg.
Molybdenum	0.2 mg.
Phosphorus	165 mg.
Potassium	5 mg.
Zinc	2 mg.



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sion of lay people in the proposal, and because the commission would be a Presidentially appointed affair, it probably would be unacceptable to the American Medical Association. Actually, however, no organization, the A.M.A. or any other which represents a special interest, is competent alone to cooperate with the Government for the good of all the people."

No Fee for Service?

Fee-for-service medicine, Author Means charges, is "scientifically indefensible." Why? "Because it makes little if any provision for preventive medicine, and because it actually makes the patient reluctant to call the doctor even when really ill. For most laymen it makes medical expense unbudgetable. Organized medicine nevertheless clings to it and is willing to fight to the last ditch to retain it."

What's the best method of paying the physician? By salary, according to Dr. Means, since it's "best for him and best for his patients . . . Economic incentives can be preserved, and there is nothing to prevent good work being done by doctors on salary—any more than there is in the case of salaried executives in business."

Some medical men, says Dr. Means, "who are most bitterly fighting what they call 'socialized medicine' are serving in the veterans' hospitals with the greatest equanimity. Yet if we have anything that

amounts to socialized medicine, the veterans' medical services are it!"

And he warns that "as veterans become ever more numerous, there is danger that the private and voluntary system of medicine . . . will become completely encircled by the free medicine (tax-supported) of the Veterans Administration. This is a far greater threat to the medical status quo and its voluntary institutions than is compulsory health insurance."

What Is 'Free Choice'?

"A great fetish," says Dr. Means, "is made of 'free choice of physician' by the stalwarts of organized medicine. But this is largely a figment of their own wishful thinking."

"What the patient wants is a good doctor. If some authority in whom he has confidence will pick one for him, he is grateful . . . In forty years experience in the public wards of Massachusetts General Hospital, I have never had a patient complain because he didn't have free choice of physician."

For anyone like James Howard Means, who likes a good fight, the loss of his sparring partner is a matter of no small moment. In his references to Morris Fishbein, Dr. Means is more amusing than he perhaps realizes. Clutching Dr. Fishbein, more or less, to his bosom, he simultaneously thumbs his nose at the current A.M.A. administration:

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manner or not, his vivid personality dramatized American Medical Association behavior in a way utterly lacking since he has left . . .

Those who hoped that the retirement of Dr. Fishbein heralded the dawn of a more liberal policy on the part of the American Medical Association were doomed to disappointment. There has been no change in policy whatever. The policy is still that of standpatism; but now there is no glamorous figure in the limelight.

"On the purely emotional side, I cannot escape some nostalgic feelings for Dr. Fishbein. Although he has taken me apart in the medical and public press, he has always been entirely courteous to me in personal correspondence, which is more than can be said for the succeeding regime . . . Moreover, he has a good sense of humor, some of which would be very valuable at American Medical Association headquarters right now. Albeit with stupendous reservations, one can, by virtue of subsequent experiences, in some measure regret his passing."

Sees Two A.M.A.s

Speaking of the A.M.A., Dr. Means says it has "a split personality—a Jekyll and Hyde affair. As Jekyll, it is a meritorious scientific body, collecting and disseminating medical knowledge for the good of humanity. As Hyde, it is a guild exerting pressure in the interest of its members."

The book warns the average phy-

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BOOKS DISCUSS ECONOMICS OF MEDICINE

sician against too much of a financial interest in his practice and too much of a proprietary interest in his patients. The author quotes Plato as having said that "the true physician is also a ruler, having the human body as a subject, and is not a mere money-maker."

He goes on to say that "the inviolability of the doctor-patient relationship has been tacitly accepted as a basic tenet of medical practice. Never must this relationship be allowed to acquire any possessive quality on the part of the doctor."

While on the subject of rules of conduct, Dr. Means also has something to say about the necessity of frankly owning up to one's mistakes: "In former times, it was true that a

doctor lost caste by admitting error, but these times are past. My experience has been that the public has increasing respect for complete candor on the part of the physician, and that nowadays he may lose more face by trying to save face than he would by admitting forthrightly his mistakes or by saying he doesn't know."

According to the jacket of his book, the doctor believes that organized medicine in the U.S. "is essentially a guild of doctors which seeks to preserve at all cost the specially privileged position of the medical profession. It is too little interested in cooperating with the government to obtain a national health program."

END

For that patient not doing as well as you'd like on
ammonium chloride, xanthines, aminophylline, resins or
other less effective diuretics

NEOHYDRIN[®]

(mixture of chlorothalidone)

normal output
of sodium and water

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Have you tasted

Meritene Doctor?

One taste tells the story. Here is the high protein nourishment patients will delight in drinking ...the sure route to *extra* nutrition whenever required, for all ages.

Let us send you a one-pound can for your own taste-test.



HIGH PROTEIN *Supplementation*
and it tastes good

MERITENE vs. EGGNOG Nutritive Value Comparison

	EGGNOG	MILK SHAKE
Protein.....	12.5 gm.	15.8 gm.
Fat.....	12.6 gm.	8 gm.
Carbohydrate.....	17.7 gm.	25.5 gm.
Calcium.....	24 gm.	5 gm.
Phosphorus.....	27 gm.	4 gm.
Iron.....	1.5 mg.	4.4 mg.
Vitamin A.....	843 I.U.	1745 I.U.
Niacin.....	12 mg.	7 mg.
Riboflavin.....	45 mg.	1.6 mg.
Ascorbic Acid.....	2.0 mg.	26.4 mg.
Cholesterol.....	288 mg.	21 mg.
Calories.....	233	237

Eggnog nutritive values from "Food Values of Portions Commonly Used." Bowes & Church, 1951.



INSTITUTIONAL SIZE PRICE
(in 100 pound quantities)—\$9¢ per pound

In the management of medical and surgical convalescence, debilitating diseases, geriatric nutritional imbalance...you immediately seek to increase the patient's protein intake.

More and more physicians are finding the answer in MERITENE—the fortified whole protein supplement that patients *like to take*. Its good taste assures that.

Therapeutic values abound in a Meritene Milk Shake: high quality protein without the burden of bulk...more of all other important vitamins and minerals than in an equal amount of Eggnog. Yet Meritene Milk Shakes costs *less*. Write for a free one-pound can . . . or mail this coupon.

THE DIETENE COMPANY

ME-34

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I am interested in becoming more familiar with MERITENE. Please send me free a one-pound can so that I can try it.

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M.D.

ADDRESS _____

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ZONE _____

STATE _____

He Takes the Pulse Of Congress

[CONTINUED FROM 106]

private office to check on work in progress. (The shock tables he developed a few years ago were standard equipment on U.S. and British naval vessels in World War II.)

From Bethesda, he drives back to Washington, stopping to make house calls on official patients. So it's generally noon before he gets to the Capitol.

There, in his three-room office suite under the Capitol dome, he's likely to see thirty-odd patients during an average day. And he may keep working right through till 1 or 2 A.M., since he remains on duty till both houses of Congress adjourn.

Medical State Secrets

Whenever the flow of patients slacks off, Dr. Calver and his staff work on the voluminous records that must be kept of all members of Congress. These records, which never leave the office, form a nearly complete medical history of that august body.

Naturally, any treatment given by Calver or his staff is immediately recorded. But even when a Congressman or a Supreme Court justice goes to another doctor, Dr. Calver asks the M.D. for a report, in order to keep his files up-to-date.

For taking such minute care of

Capitol Hill health needs, the doctor is paid \$10,000 plus living expenses—the standard salary for a rear admiral. To his patients, the service is, so to speak, free. The only fees a Congressman or Supreme Court justice must pay are for hospital care.

His Patients Are Loyal

Dr. Calver insists that his "health management" doesn't replace the family doctor; but he admits that some legislators seldom consult any other Washington M.D. Even when Congress isn't in session, enough of its members and employees stay in town to warrant keeping the office open a couple of days a week. And when a session is nearing its end, the three-room suite is sometimes crowded with lawmakers clamoring to be given the once-over before taking off.

Actually, most of them would probably come to Dr. Calver even if his services weren't free and even if he were less personable. Chief reason: Ever since his China Sea days, he has specialized in the treatment of the middle-aged male.

So when a Congressional veteran starts worrying about his health, he knows he can have confidence in his official doctor. He knows he will be consulting, in Dr. Calver, not merely a cardiologist and diplomate in internal medicine but also a Fellow of the American Geriatrics Society.

Dr. Calver himself sums up his work this way: "It's my responsibil-

The old man's picking up these days!

Of course — the additional easily digestible protein in Knox Concentrated Gelatine Drink probably helps too!

HOW TO ADMINISTER KNOX CONCENTRATED GELATINE DRINK

Each envelope of Knox Gelatine contains 7 grams which the patient is directed to pour into a $\frac{1}{4}$ glass of orange juice, other fruit juices or water, not iced. Let the liquid absorb the gelatine, stir briskly, and drink at once. If it thickens, add more liquid and stir again. Two envelopes or more a day are average minimal doses. Each envelope contains but 28 calories.

FOR YOUR PATIENTS' PROTECTION

Be sure you specify **KNOX** so that your patient does not mistakenly get factory-flavored gelatine dessert powders which are 85% sugar.



AVAILABLE AT GROCERY STORES IN 4-ENVELOPE FAMILY SIZE AND 32-ENVELOPE ECONOMY SIZE PACKAGES.

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ALL PROTEIN • NO SUGAR

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- ☐ Reducing Diet, ☐ Diabetic Diet,
☐ Low Salt Diet.

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STREET _____

CITY _____ TOWN _____ STATE _____

WHEN WILL-POWER
WEAKENS...



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REDucing Vitamin CAPSules

ACHIEVE 3 THERAPEUTIC GOALS:

Depress the appetite with bulk-producing, inert methylcellulose — plus appetite reducing d-amphetamine.

Elevate the mood, making the patient more willing to follow a reducing diet.

Prevent dietary deficiencies by supplementing the diet with the vitamins and minerals so often lacking in an unsupervised reducing regimen.

Patients find it easy to follow the simple dosage directions: 1-2 capsules, $\frac{1}{2}$ to 1 hour before each meal.

Available on prescription only.

*Trade Mark



LEDERLE LABORATORIES DIVISION

AMERICAN Cyanamid COMPANY

Pearl River, New York

PULSE OF CONGRESS

ity to keep the human machinery of the national Legislature in top operating condition. It's a job I enjoy."

How He Relaxes

Like many another sailor, he also enjoys farming. Three years ago, he bought a 520-acre farm in southern Maryland. And this provides his major form of recreation.

On week-ends (and often during the week, when Congress is out of town), he supervises the tilling of his corn and soybeans (150 acres) and does some carpentry, too. The farm also serves as vacation headquarters for the doctor and his wife, their two married daughters, and their eight grandchildren.

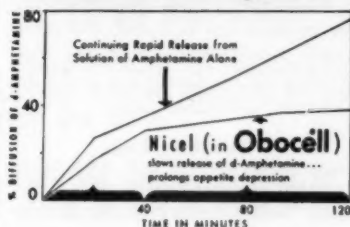
Some day it will be a permanent home. But George Calver has no plans for retirement in the near future. For one thing, his post can be filled only by Congressional dispensation; and Congress shows no signs of wanting a change. END

No More Dust

Whenever I used my electric cast cutter, the treatment room would get powdered with plaster dust. But no more. Now, my aide holds the narrow nozzle of a tank-type vacuum cleaner an inch or two from the blade, thus drawing up every fleck of dust as it appears.

—M.D., New Jersey

- Metered Medication without enteric coating
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- Prompt at meals
- Sustained between meals



Obocell

Helps keep your patients on diets longer . . . economically

A rapid, short-acting phase of drug release curbs appetite before meals.

Through the action of Nicel,* Obocell sustains control between meals, prevents diet violation by suppression of bulk hunger.

Obocell's metered medication spares your patients the "bumps" and "dumps" of unpredictable amphetamine activity.

In addition . . . Obocell is economical . . . reduces your patient, not his pocketbook.

Each Obocell tablet contains:

Dextro-amphetamine phosphate, dibasic	5 mg.
Nicel*	150 mg.

*Nicel—Irwin-Neisler's Brand of High-Viscosity Methylcellulose.

Supplied: Bottles of 100, 500, 1000.

Obocell®

Doubles the power to resist food

**IRWIN, NEISLER & COMPANY
DECATUR, ILLINOIS**

If Fire Strikes, Will Your Policy Pay Off?

[CONTINUED FROM 145]

Collecting for damage to furniture or professional equipment is obviously a complicated business. Collecting for a building loss seems, by contrast, deceptively easy.

Building Loss

After you've reported such a loss, your broker or the insurance adjuster will tell you to furnish a contractor's estimate of how much it will cost to rebuild the damaged property. The adjuster will either accept this estimate or—if it sounds unrea-

sonable to him—will have one made on his own. He'll then go over the replacement figures, to knock off percentages for depreciation on the old building.

But his estimates for depreciation will probably be a lot more drastic than yours. So, before you submit your proof of loss, make a note of anything that tends to make the destroyed or damaged parts especially valuable.

For example, the average shingle roof lasts about fifteen years. But perhaps your old roof was made of specially treated shingles, designed to last at least twenty-five years. Emphasize this fact.

By the same token, mention any recent remodeling, redecorating, or

No other rauwolfia product offers such

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ration any
rating, or

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11

In Neuritis—

is temporary relief enough?

Now—



**THE LONG PERIOD OF DISTURBING
SYMPTOMS CAN BE REDUCED BY THE
PROMPT USE OF—**

PROTAMIDE

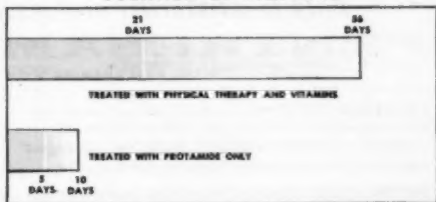
When you have a case of neuritis (intercostal, facial or sciatic) where the inflammation of nerve roots is not caused by mechanical pressure, let Protamide demonstrate how much faster lasting relief can be obtained than with usual therapy. Usual dose: one ampul every day for five days or longer.

NEURITIS

(Sciatic • Intercostal • Facial)

A COMPARISON BETWEEN COMPARABLE GROUPS WITH AND WITHOUT PROTAMIDE THERAPY

DURATION OF SYMPTOMS



CONTROL—156 Patients
The Course of the Disease
Was 21 Days to 56 Days

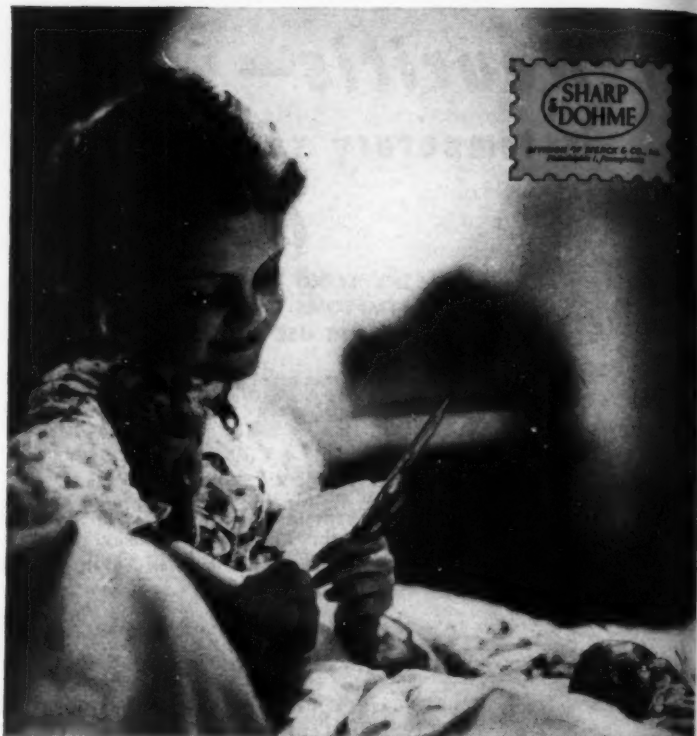
PROTAMIDE—84 Patients
Complete Relief was
Obtained in 5 to 10 Days

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"TREATMENT OF NEURITIS WITH PROTAMIDE"

Richard T. Smith, M.D.
Associate in Medicine and Chief of
Arthritis at Jefferson Medical College
and Hospital; Associate Physician and
Chief of Arthritis, Pennsylvania Hospi-
tal; Director of Department of Rheu-
matology, Bascom Franklin Clinic.

REPRINTS AVAILABLE



PHOTOGRAPH BY PAUL NABE

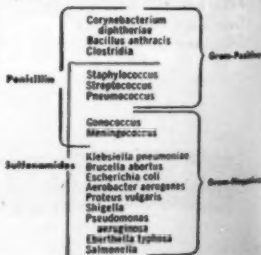
Easy-to-administer oral antibacterial therapy
PENTRESAMIDE® - 250
 TRIPLE SULFONAMIDE WITH PENICILLIN

ACTIONS AND USES: PENTRESAMIDE Tablets provide the combined antibacterial activity of penicillin and sulfonamides—in many susceptible infections more effective than either agent used alone. They are especially useful in mixed infections.

SUPPLIED: Tablets in bottles of 60 and 250. Granules for suspension in water in dispensing bottle containing 6 Gm. triple sulfonamide and 3,000,000 units buffered penicillin G. One tablet or one teaspoonful of suspension provides: 0.1 Gm. sulfamerazine, 0.2 Gm. sulfadiazine, 0.2 Gm. sulfamethazine and 250,000 units of potassium penicillin G.

DOSAGE: Adults, 1 or 2 tablets or teaspoonfuls q.i.d. Children, by weight and condition. Dosage schedule on request.

Wider Antibacterial Range



IF FIRE STRIKES, CAN YOU COLLECT?

restoration work. And be prepared, if necessary, to show receipted bills as evidence.

Restoration 'As Was'

In addition to considering depreciation, the adjuster will want to know whether your contractor's estimate includes any improvements that weren't in the old building. It's likely, of course, that you'll want to make some changes, now you're forced to rebuild. But you'd better be prepared to have the adjuster make drastic reductions in your claim for any improvements he spots.

With this in mind, simply give him an estimate that applies to "as was" restoration.

Then, after reaching an agreement, you can have improvements added to the contractor's plan at your own expense.

When the adjuster has matched your estimates against his, he'll give you his version of the cash value of your loss. If you accept it, he'll draw up a "proof of loss" form for you to sign. Within a reasonable time, then, you'll get a check from the insurance company—and the matter will be closed.

If You Disagree

But what if you don't want to accept the adjuster's estimate? In that case, it's often best to drag your feet a bit; adjusters *do* sometimes make a purposely low estimate for bargaining purposes. On the other hand,

yours may flatly refuse to compromise. In the latter event, you're left with three alternatives to accepting his offer:

1. You can employ a public adjuster. He's a licensed specialist, with the same kind of training as a company adjuster; and he'll competently represent your interests in dealing with the company—for a fee of perhaps 10 per cent of the settlement.

2. You can require arbitration. Your policy probably provides that you'll be allowed to appoint one person and the insurance company a second. The two appointees, in turn, will choose a third.

3. Finally, you can take the case to court. But most insurance counselors advise this only as a last resort—and if the amount involved is large. Battling an insurance company in court can be a frustrating and costly experience.

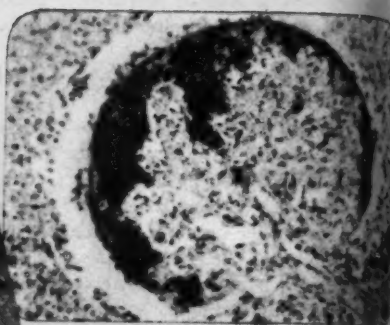
END

Medical Keys

Ordering a new typewriter? A number of manufacturers put out special models with keys bearing often-used medical symbols. Or you can ask your typewriter repair shop to order such keys to replace little-used ones ($\frac{1}{4}$, $\frac{1}{2}$, for instance) on your present machine. The cost, including purchase price and installation: probably not much more than a dollar per key.



Show gross specimens...



Show photomicrographs...

Show your color slides...brilliantly...

Here is the ideal viewer for your consultations, or for discussions, small teaching groups, editing. Handsome, durable construction. It gives you a large, clear, crisp, full-color image. Price \$97.50.

Also available: Kodaslide Table Viewer, 4X. Price \$37.50. (Prices are subject to change without notice.)



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Show before-and-after records...

ntly... easily... with the
Kodaslide Table Viewer, Model A...

Now you can show your 2 x 2-inch slides—enlarged nearly five times—right at your desk, without fuss or bother—even in a fully lighted room.

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TRADE-MARK

pain

has two aspects

physical

psychic

Daprisal*

relieves both aspects of pain

physical—because it provides the combined analgesic effect of acetylsalicylic acid and phenacetin, potentiated by amobarbital.

psychic—because it provides the mood-ameliorating effect of Dexamy† (Dexedrine† and amobarbital).

Smith, Kline & French Laboratories, Philadelphia

*Trademark †T.M. Reg. U.S. Pat. Off.

†T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

This Study Plan Meets G.P.s' Needs

[CONTINUED FROM 129]

classes. For its part, the institute guaranteed to provide visual aids, written materials, and instructors.

Last year, 450 M.D.s signed up for the out-of-town classes. And, as proof of their value, the institute proudly points to the attendance figures: About 90 per cent of the enrolled doctors were present at all sessions.

Says a New Bedford G.P.: "After attending post-graduate courses for forty-two years—and having to travel to get there—I've found it a joy to

have these distinguished teachers come to me."

This warm support means much to both speakers and institute planners. But it isn't only the doctors who are enthusiastic. Increasing numbers of Massachusetts medical schools, hospitals, and foundations have granted funds to the Postgraduate Medical Institute.

With such help, it's now able to make token payments to teachers (\$15 per session in Boston; \$50 plus expenses for an out-of-town session).

Practical Results

Would Massachusetts medical men recommend similar programs for areas that don't yet have them? They certainly would. "We know

HEMORRHOIDS
POST-HEMOR-
RHOIDECTOMIES
POST-EPISIO-
TOMIES
EXANTHEMAS
ECZEMAS
PRURITUS
WOUNDS
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PROMPT RELIEF

FROM SURFACE PAIN AND ITCHING

Via 20% Dissolved Benzocaine

Clinical studies show nothing relieves surface pain and itching like Americaine . . . because only Americaine contains 20% dissolved benzocaine . . . the first time such high concentration has been achieved. Shown to be more effective¹, quicker acting², longer lasting³, least toxic⁴.

1. Tainter, M. L. & Winter, L.: *Anesth.* 5:470
2. White, C. & Madura, J.: *Postgr. Med.*, June, 1951
3. Schmitz, H. E. et al: *West. J. Surg. & Gyn.*, 59:117
4. Adriani, J.: *Pharmacology of Anesthetic Drugs*, 1941

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In Canada: Brent Laboratories, Ltd., Toronto

Americaine
TOPICAL ANESTHETIC OINTMENT

THIS STUDY PLAN MEETS G.P.'S' NEEDS

there are obstacles, especially for small medical societies with few members," says one institute official. "But a little money and a lot of energetic planning can go a long way."

Clearly, the results justify the effort. Here are just four examples of how the G.P.s have profited from the program:

¶ A New Bedford physician tells of having learned from an institute course how ovarian cysts can be treated by the oral administration of drugs designed to curb hormonal effects. As a result, at least one of his patients was spared surgery.

¶ In Milford, a family doctor successfully treated a rheumatic fever patient with cortisone, after having studied current methods of using it.

¶ "Cancer detection in gynecology has helped me prolong the lives of several patients," says a Pittsfield man. "What I needed was the kind of updating made possible through institute courses."

¶ A Fall River M.D., recognizing an unusual complication, saved the life of a maternity patient. "I was able to make the diagnosis," he says, "chiefly because I had attended an institute lecture three weeks earlier."

A Worcester G.P. sums up overall reaction to the program this way:

"At last we're getting some practical training that really counts. Best of all, we're getting it with a minimum of time and effort on our own part—which is just what the busy doctor ordered."

KMB

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MOUTHWASH AND GARGLE

**So much more
than merely a
mouth rinse**

Actually!

Lavoris acts both chemically and mechanically to break up and flush out the germ-harboring, odor-producing mucus accumulations from mouth and throat. It stimulates capillary circulation with attending improvement of tissue tone and resistance.

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OF MERIT FOR
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saved the
t. "I was
" he says,
ended in
s earlier."

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the boy

END



A New NION development. for therapeutic control of **MOTION SICKNESS**

Each tablet contains:

Scopolamine HBr . . 0.15 mg.
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A prescription item only.
Available in bottles of 100

NIO-PIRACENE



Clinical Tests Prove 92% Protection⁽¹⁾

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(1) MacKay, E., Stanford Medical Bulletin: In Press 1954



Who Will Run the Blood Banks ?

[CONTINUED FROM 135]

men made two major compromises (one critic calls them "a complete retreat"): They agreed that no charges would be made to patients for blood or service, and that no pressure would be put on patients to replace blood.

Doctors Get a Voice

The Red Cross, for its part, agreed to give doctors a major say in the running of the blood bank. The chairman of the board of directors, it was stipulated, would be a medical society appointee; furthermore, the board and blood-bank personnel would at all times be under the direction of a technical committee appointed by the medical society.

Problems have, of course, cropped up—but most of them, Dr. Dennis declares, have been satisfactorily solved. One early difficulty was the discovery that people didn't respond to an appeal for blood "simply as a result of being informed of the need." So Red Cross officials agreed to permit the formation of "credit clubs." They even began asking patients to replace blood.

Through compromises like this, says Dr. Dennis, the blood bank has managed to stay in operation. (The existence of a contract that formally spells out the responsibility of each party also helps.) [MORE→]

Prompt, prolonged, prescribed

relief of tension headache

APROMAL

(acetylcarbamol and N-acetyl- β -aminophenol, Ames, 0.15 Gm. ea.)

sedative-analgesic

direct-acting pain relief
mild "daytime" sedation • outstanding tolerance
non-narcotic, non-barbiturate
wide margin of therapeutic safety

"to relieve headache and other aches and pains of functional disorders" analgesics "are usually more effective when combined with a sedative."

Watts, M. S. M., and Wilbur, D. L.: J.A.M.A. 152:1192 (July 25) 1953.

Samples and literature upon request.



AMES COMPANY, INC.
ELKHART, INDIANA

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MEMO

You asked for it



Kleenex Tissues back in the **WHITE** box

PACKED IN THE NEW 24-BOX SHIPPING CASE

Yes, Kleenex* 200's are back in the White Box so many professional people have asked for. And now in the convenient case of 24 boxes. No more storage worries! Lower delivery costs! Your dealer can ship Parcel Post.

You'll find dozens of office uses for Kleenex — mopping up spilled liquids, dusting, polishing and personal use by patients.

Kleenex in the White Box is available to professional people only. Order through your supply dealer (Code No. 5101 — 24 boxes, 200 sheets per box).

*T. M. REG. U. S. PAT. OFF.

The bank has been a statistical success, too. In 1948, it was handling about 400 productive donors a month; by last year, the figure had shot up to 6,000 a month. During the same period, the cost of handling a 500-cc. unit of blood (from donor to physician) dropped from \$11 to less than \$4.

Complications Ahead?

Can such cooperation be achieved on a national scale? Dr. Dennis believes it can. But he admits that it will take time.

Just persuading doctors and the Red Cross to *start* working together effectively is a formidable job. It becomes even harder in the face of the nearly 1,500 hospital and communi-

ty blood banks already in independent operation. As noted before, these banks already contribute more than half the blood used in civilian hospitals. Through their organization, the American Association of Blood Banks, they can be expected to fight any attempt to force them into a back-seat position.

On the basis of what's been done so far, then, it would be premature to predict early agreement on any single program for handling the country's blood banks. The chances are, though, that a single program will eventually come about—either by increased cooperation between organized medicine and the Red Cross or by the squeezing out of one by the other.

END

Serpasil

C I B A

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From the desk of
R. A. SUTTER, M. D.

SWELL
for Kids!



INSTANT RALSTON
Extra-Nutritious!
Whole Wheat with
5% Extra Wheat Germ

My kids love it
cooks Quick...
just 10 seconds



Kymographic recording shows normal contraction of rabbit jejunum in 100 cc. of Tyrode's solution.

When the EMETROL solution is replaced with fresh Tyrode's solution, normal contraction resumes.

Adding 0.5 cc. of EMETROL immediately relaxes the muscle... reduces rate and amplitude of contraction.

With 1.0 cc. of EMETROL, these effects become much more marked.

this is why **EMETROL** controls

(PHOSPHORATED CARBOHYDRATE SOLUTION)

EMETROL Phosphorated Carbohydrate Solution permits effective physiologic control of functional nausea and vomiting—without recourse to antihistaminics, sedatives, or hypnotic drugs.

Pleasantly mint flavored, EMETROL provides balanced amounts of levulose and dextrose in coating association with orthophosphoric acid, stabilized at an optimal, physiologic

Kinney

SAMPLE AND LITERATURE TO

When the EMETROL solution is replaced with fresh Tyrode's solution, normal contraction resumes.



Contraction virtually ceases with addition of 1.5 cc. of EMETROL.



Control epidemic vomiting physiologically

logically adjusted pH level.

Thus, EMETROL can be given *safely*—by teaspoonfuls for children, tablespoonfuls for adults—at repeated intervals until vomiting ceases.

IMPORTANT: EMETROL is always given *undiluted*. No fluids of any kind should be taken for at least 15 minutes after taking EMETROL.

INDICATIONS: Nausea and vomiting resulting from functional disturbances, acute infectious gastroenteritis or intestinal "flu," pregnancy, motion sickness, and administration of drugs or anesthesia.

SUPPLIED: Bottles of 3 fl.oz. and 16 fl.oz., at all pharmacies.

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SEPTISOL used regularly keeps your hands surgically clean.

SEPTISOL'S cumulative action keeps on killing bacteria—even many hours after washing.



Free plastic Dispenser with each gallon of Septisol

SEPTISOL is non-irritating to the normal skin. Natural vegetable emollient leaves your hands soft and truly clean. SEPTISOL is a concentrate; one gallon makes two gallons of "use" solution.

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Company and Private M.D.s: *Must* They Feud?

[CONTINUED FROM 160]

given informal briefings on such matters as chemical exposure, safety hazards, and the nature of various jobs.

Medical leaders believe that much of the current friction can be eliminated by such means. Basically, they contend, the intraprofessional difficulties connected with industrial medicine must be tackled on a grass-roots level. And they point out that whenever plant physician and private medical man are willing to talk things over, they usually find answers to some pretty knotty problems. Here's a true story bearing out this assumption:

One Phone Call Helps

A young woman, employed by a Southern textile manufacturing company, had for a number of weeks missed coming to work on Mondays and Tuesdays. Every Wednesday, she showed up with a doctor's note claiming that she had suffered from "gastritis" or "gastroenteritis." It didn't take much investigation to convince the plant physician that (1) the woman was an alcoholic; (2) her family physician was covering up for her.

"I phoned her doctor," recalls the company man, "and pointed out that she had missed twelve days in less than two months. He seemed

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Feud?

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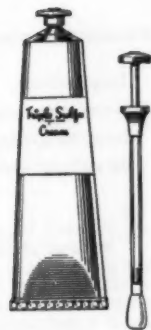
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in postpartum care



multiple sulfonamides
for maximum effectiveness

reduces postpartum morbidity
lessens discomfort
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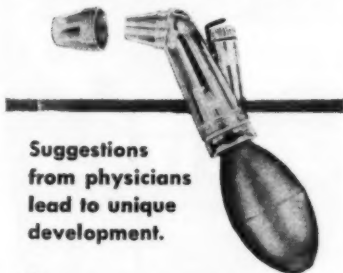


Triple Sulfu Cream

TRADE MARK
in postpartum care
in nonspecific leukorrhea
after cervical conization



New No. 41
Pocket Nebulizer by
DeVILBISS
fills long-felt need



**Suggestions
 from physicians
 lead to unique
 development.**

✧ Spurred by suggestions from the medical profession, DeVilbiss has now perfected the *first* successful pocket nebulizer which the asthmatic may carry with him at all times, ready to use at a moment's notice.

Leak proof, practically unbreakable. Provided with attractive carrying case. Weighs but an ounce and a half. Particle size and performance, equal to that of standard-size nebulizers. Ask your pharmacist to stock the new DeVilbiss No. 41 Pocket Nebulizer. \$5.00 cost to patient. The DeVilbiss Company, Somerset, Pa., and Barrie, Ontario.

**DeVILBISS • ATOMIZERS
 NEBULIZERS
 VAPORIZERS**

SOMERSET, PA.

"The Line the Physician Knows and Prescribes"

The DeVilbiss Company Department "E"
 Somerset, Pa.

Enclosed is \$1.00 for DeVilbiss No. 41 Pocket Nebulizer, a special introductory offer limited to the medical profession.

NAME..... M. D.

STREET.....

CITY.....STATE.....

(Not valid after June 1, 1954)

COMPANY M.D.S

surprised—said he hadn't realized she'd been out *that* much. Then he explained that he'd been writing the certificates because the woman was afraid of losing her job.

"But I told him that it was only a matter of time before we'd have to let her go, anyway. We agreed, of course, that what she really needed was hospital treatment and rehabilitation; so he promised to see that she got it, after I assured him that she'd have a job with us whenever she was ready to return."

Naturally, cooperation can't always be achieved through a single telephone call. But whether or not it's easy to come by, it offers the only real road to a lasting peace between the industrial physician and the private practitioner.

END



**"How long have I had
 what flutter?"**

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Bonamine*

Brand of meclizine hydrochloride

the
first compound
effective
against motion
sickness in
a single
daily dose

most prolonged action

Bonamine is the only motion-sickness preventive which is effective in a *single daily dose*. Just two 25 mg. tablets (50 mg.) will provide adequate protection against all types of motion sickness—car or boat, train or plane—for a *full 24 hours in most persons*.

few side effects

Clinical studies have shown, in case after case, that relatively few of the patients experienced the usual side effects observed with other motion-sickness remedies: less drowsiness, dullness, headache, dryness of the mouth, etc. In addition, Bonamine is tasteless and acceptable to patients of all ages. 25 mg. tablets.

Supplied: 25 mg. tablets.



PFIZER LABORATORIES Brooklyn 6, N.Y.
Division, Chas. Pfizer & Co., Inc.

*TRADEMARK

Musterole[®] breaks up chest colds'

CONGESTION in nose, throat and upper bronchial tubes!

Musterole promptly relieves coughs and aching soreness of chest colds. It starts right in to break up painful local congestion.

Musterole's highly stimulating, pain-relieving medication creates *concentrated* heat on chest, throat and back. It acts just like a poultice.

- **PROFESSIONAL SAMPLES** without charge on request to The Musterole Company, Cleveland, Ohio.

Typical OCEAN HOUSE unit



PEACE and PRIVACY

**... yet merely minutes from
Florida's finest attractions!**

OCEAN HOUSE is tucked away on its own private beach—quiet, uncrowded, spacious. But it's close to tracks, golf, fishing, and all attractions from Miami to Lauderdale. One and two-bedroom apartments, completely modern, each facing beach and ocean. Write for moderate spring rates and descriptive literature.

OCEAN HOUSE

Box 402

HOLLYWOOD-BY-THE-SEA, FLORIDA

"Private as your own Desert Islet"

Choosing a Location: Judging the Community

[CONTINUED FROM 112]

communities come these additional tips:

¶ Be sure to write to the local medical society for information before you make your personal inspection. "Often the reply will reflect the prevailing opinions and attitudes of the local doctors and so forewarn you," says a Colorado general practitioner.

Hospital Privileges

¶ Early in your visit, check with the hospital director and officers of the medical staff. "Some hospitals," reports an Illinois physician, "won't grant you any privileges till you've been in the community several months, and then will put you on probation for a year before giving you full privileges."

¶ If you're a specialist, check up on the attitude of the local G.P.s toward your specialty. In some areas, where G.P.s have been doing anesthesia, general surgery, and other specialty procedures, specialists in those fields are apt to find the going rough.

¶ If it's a small community in need of a doctor, find out how many doctors before you have come and gone—and why they left. "Get in touch with them directly, if you can," a Kansas rural practitioner advises. "You may learn things you'd

NEWS!

Doctors Anticipate "Quads"!



Gerber's "Quads", of course! New small sizes of Gerber's four starting cereals . . . neatly packaged together in cellophane. Rice, Barley, Oatmeal, and Cereal Food (a mixed cereal) combined for greater ease in rotating variety, in determining infant preference, in convenience for young mothers.



SELECTIVITY. When variety of flavor is indicated, Gerber's "Quads" give assurance the young mother will rotate all four enriched cereals. In cases of suspected allergy, "Quads" involve little waste during "elimination" period.

INFANT ACCEPTANCE. Gerber's Cereal "Quads" are highly acceptable to babies because of extra-smooth texture, pleasant mild flavors. It's simple to discover which cereal varieties the baby *prefers*. The regular 8 oz. size of Gerber's Cereals may be recommended as baby's appetite increases.



Babies are our business...
our *only* business!

Gerber's
BABY FOODS

4 CEREALS • 60 STRAINED & JUNIOR FOODS.
INCLUDING MEATS

Samples Free! Write on your letterhead for special individual packets of Gerber's 4 Cereals for professional use. Dept. 223-4, Fremont, Michigan.

CHOOSING A LOCATION

have to learn by bitter experience otherwise."

¶ Meet as many as possible of the doctors who will be your near neighbors or competitors. A Utah M.D. says: "If there are ten of them, you may get ten different opinions as to your chances; but it shouldn't be difficult to sort out the significant ones."

¶ Talk to the local pharmacists. "They'll sometimes paint an unjustifiably rosy picture of the possibilities," says a Tennessee physician. "But they can also give you the straight facts about the local doctors—including some things the doctors themselves might hesitate to mention."

Lastly—and perhaps most impor-

tant—be your own Sherlock Holmes, whenever possible.

Of course, you'll *have* to depend on prospective neighbors, real estate men, the chamber of commerce, and the local medical society for much of your information. But you can still check statements with more than one source and compare them with available facts and figures. Only by so doing will you get a fairly true picture, unshaded by other people's emotions and prejudices.

There's no guarantee that these check-lists—or any others—will guard you against mistakes in judgment. But if you keep your eyes open, the laws of probability, at least, will be on your side in your search for a good location. END



aspergum
for sore throat

specifically designed
to relieve throat soreness
through prolonged direct
contact of aspirin.


White Laboratories, Inc.
Kenilworth, N. J.

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Out In front...

*in treatment
of
hypertension*



Raudixin

SQUIBB RAUWOLFIA

More physicians write prescriptions for Raudixin than for all other forms of rauwolfia combined. The reasons for this choice are sound:

- Raudixin contains the standardized *whole root* of *Rauwolfia serpentina*. There is no definite evidence that any alkaloid or fraction has all the beneficial actions of the whole crude root.
- Raudixin lowers blood pressure moderately, gradually, stably. It also slows the pulse and has a mild sedative effect.
- Raudixin is the *safe* hypotensive agent. It causes no dangerous reactions and almost no unpleasant ones.
- Raudixin is often effective alone in mild to moderate hypertension of the labile type. In more severe cases it is effectively combined with other hypotensive agents.

50 and 100 mg. tablets, bottles of 100

SQUIBB

RAUDIXIN® IS A TRADEMARK

when the problem in hypertension is to

**maintain
response**
to therapy

RUTOL*

IS THE LOGICAL FORMULA

EACH TABLET CONTAINS:

Mannitol hexanitrate.....16 mg.⁽¹⁾
Rutin.....10 mg.
Phenobarbital..... 8 mg.

⁽¹⁾ This specially-designed formula permits dependable nitrite therapy with less risk of developing nitrite tolerance.

Rutol is particularly favored by physicians advocating "interrupted" nitrite therapy—to maintain *maximal* therapeutic re-

sponse. The 16 mg. ($\frac{1}{4}$ gr.) of mannitol hexanitrate in Rutol Tablets provides the established *minimal effective dose*—together with a prophylactic dosage of rutin, to guard against vascular accidents, and phenobarbital, for cerebral sedation.

PITMAN-MOORE COMPANY

Division of Allied Laboratories, Inc.

Indianapolis 6, Indiana

*TRADE MARK

News

Calls hospital shortage still acute • Syphilis making a comeback? • Criticizes lay medical articles • More opposition to dependent-care plan • Doctors losing individuality? • Physician tells public about euthanasia

Charts Broad Campaign Against Chronic Ills

A medical spokesman for the Eisenhower Administration believes that chronic diseases "now constitute our greatest challenge in the field of public health." In making this point, Dr. Chester Scott Keefer, the top medical man in the Department of Health, Education, and Welfare, adds that such ailments "present far more difficult problems and demand more complex action" than do communicable diseases.

So he proposes a partnership of Government and private medical men in order to wage a full-fledged assault on chronic ailments. Such an assault, he suggests, would call for the following steps:

1. Development of new techniques to identify chronic diseases "in their early stages."

2. Research to "discover and, if possible, eradicate the now obscure causes of such conditions as hypertension, arteriosclerosis, and nervous disorders."

3. The mustering of adequate personnel and hospitals to care for the chronically ill.

4. Public education about the menace of chronic illness.

5. A fund-raising drive to finance the over-all program.

After 18 Years, Voila! A New Medical School

Paris has a brand new medical school building—but only after nearly twenty years of typically Gallic struggle. The story as it unfolded:

In 1935, the University of Paris was all set to break ground for a projected medical center (including several hospitals as well as the school). But, at the last minute, the wine merchants who owned the property on which the huge project was to rise boosted their selling price; the idea was abandoned.

A year later, the university lowered its sights and blueprinted a modest nine-story edifice. But excited residents of the Left Bank, where it was to be constructed, ar-



You can prevent attacks in angina pectoris

Peritrate prophylaxis effective in 4 out of every 5. Humphreys *et al.* noted that Peritrate reduced the number of attacks in 78.4 per cent of patients and "... patients with the greatest number of attacks showed the greatest reduction."¹ Complementing this finding, Russek and co-workers observed that their results in angina pectoris patients receiving Peritrate were "... comparable to those obtained with glyceryl trinitrate, but the duration of action was considerably more prolonged."²

Freedom from attacks with significant ECG improvement. Freedom from attacks during Peritrate prophylaxis in verified angina pectoris is usually accompanied by significant ECG improvement. Peritrate has been effective in preventing S-T segment

shifts occurring after exercise in many angina pectoris patients.¹

Simple regimen helps patient "keep up with the crowd." Peritrate, a long-lasting coronary vasodilator, will reduce the nitroglycerin need in most angina pectoris patients.³ A continuing schedule of one or two tablets 4 times daily will usually

1. reduce the number of attacks
2. reduce the severity of attacks which cannot be prevented.

Available in 10 mg. tablets in bottles of 100, 500 and 5000.

1. Humphreys, P., *et al.*: *Angiology* 3:1 (Feb.) 1952. 2. Russek, H. I.; Urbach, K. F.; Doerner, A. A., and Zohman, B. L.: *J.A.M.A.* 153:207 (Sept. 19) 1953. 3. Ploetz, M.: *New York State J. Med.* 52:2012 (Aug. 15) 1952.

Peritrate®

TETRANITRATE
(BRAND OF PENTAERYTHRITOL TETRANITRATE)

WARNER-CHILCOTT Laboratories, NEW YORK

gued that a "skyscraper" would be out of place and that the crowds of students would bottle up narrow streets in the area. So architects snipped the top floor off their plan and arranged to have the building set back from the street.

Then, in 1940, with construction finally under way, the Nazis swept into Paris and took over the steel framework for gun emplacements.

It wasn't till 1947 that the university was able to scrounge up enough materials to resume construction. The job is now complete—about eighteen years behind schedule.

False Colors?

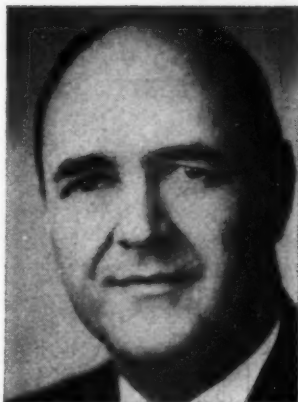
Since men in white traditionally frighten youngsters, a St. Louis children's dentist has decided to defy tradition:

In his office, Roy M. Wolff now wears a colored sports shirt, yellow trousers, and green shoes. (Less cheerful note: He still uses a drill.)

Says Hospital Shortage Remains Acute

There's apparently little hope that the nation's shortage of hospital beds will be eased in 1954. The situation as seen by Dr. John W. Cronin, who heads the division of hospital facilities of the U.S. Department of Health, Education, and Welfare:

Despite an unprecedented boom in hospital construction since the



DESPITE THE BOOM in hospital construction, John W. Cronin points out that bed supply is lagging far behind demand.

end of World War II, supply simply hasn't been able to catch up with increasing demands "arising from population growth and obsolescence of existing facilities. So we still have an estimated accumulated backlog deficit" of about 850,000 beds—only a slight drop from the 900,000-bed deficit of 1946. And, he adds (in an article in the magazine *Hospitals*), it would cost about \$12 billion to satisfy present needs in full.

This figure dwarfs the roughly \$4.5 billion that has been spent on hospital construction (by both Government and private sources) since World War II. Yet, according to Dr. Cronin, annual outlays have been tapering off since 1951; he estimates



An Unusually Unresponsive Arthritis— Severely Painful, Recurrent

Consider gouty diathesis as the cause. "Chronic gouty arthritis may be confused with osteoarthritis, post-gonorrheal rheumatoid arthritis and adult rheumatoid arthritis."¹

Fortunately, there is a sure diagnostic test for gouty arthritis—gout should be suspected if "symptoms are *relieved* within 24 to 72 hours by adequate doses of *colchicine*."²

Specifically designed to meet the demands
of gouty arthritis therapy—

CINBISAL 'McNeil'
TRADE MARK

—provides colchicine (0.25 mg.) for its specific effect; sodium salicylate (0.3 Gm.) to combat pain in hyperuricemia; ascorbic acid (15 mg.) to replace vitamin C lost during salicylate therapy.

CINBISAL is supplied in bottles of 100 and 1000 tablets. (Engestec® coated green.) Samples on request.

IN ACUTE CASES—medical management includes two tablets Cinbisal (equivalent to colchicine 0.5 mg. and sodium salicylate 0.6 Gm.) every hour until pain is relieved, unless gastrointestinal symptoms appear. (Eight to ten doses are usually sufficient.)

TO PREVENT RECURRING ATTACKS—two to six tablets daily.

McNEIL LABORATORIES, INC. Philadelphia 32, Pa.

1. Comroe, B. I.: Arthritis and Allied Conditions, Philadelphia, Lea & Febiger, 1949, p. 734.

2. Ibid, p. 735.

For growth and appetite
in below-par children



TROPHITE*

B₁₂ plus B₁



The only high potency combination of two growth-promoting, appetite-stimulating factors in two dosage forms.

In each teaspoonful (5 cc.), and in each tablet:

25 mcg. of B₁₂ the "marshalling agent which effects reorganization of a variety of metabolic derangements involved" in simple growth failure.¹

10 mg. of B₁ the factor whose value in combatting anorexia and deficient growth has long been known.²

Recommended dosage: Only one teaspoonful or one tablet daily.

1. Wetzel, N.C.; Hopwood, H.H.; Kuechle, M.E., and Grueninger, R.M.: *Clinical Nutrition* 1:17 (Sept.-Oct.) 1952.
2. Best, C.H., and Taylor, N.B.: *The Physiological Basis of Medical Practice*, Baltimore, Williams & Wilkins, 1950.

Smith, Kline & French Laboratories, Philadelphia

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that the 1954 expenditure will be less than \$590 million—the lowest total since 1948.

Small Fry 'Eat Up' Ice Cream Prescriptions

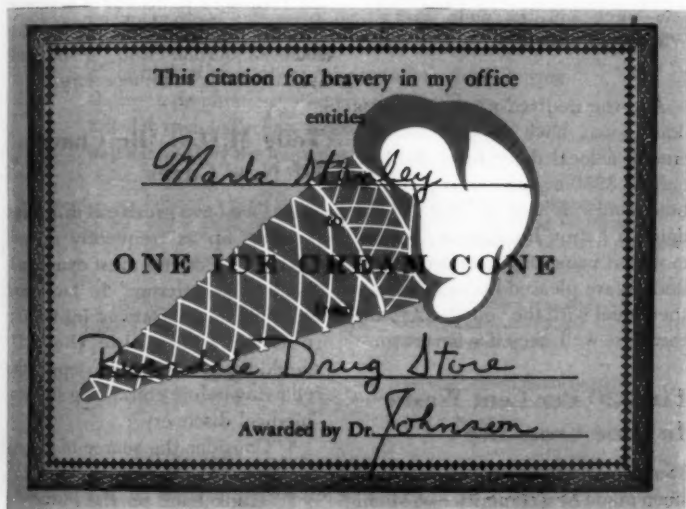
How can you boost your stock with pint-sized patients? Here's one device that's being used increasingly by physicians everywhere:

At the conclusion of an office visit, they give youngsters a "citation for bravery." No empty honor, it entitles the bearer to a coveted award: one ice cream cone, any flavor, available at a neighborhood drug-

store. The doctor regularly redeems the citations and pays the tab.

Evidence that the idea is catching on: The Professional Printing Company of New Hyde Park, N.Y., which has been turning out the "citations" for about a year, reports it's knee-deep in orders for the forms.

But though new to some doctors, the ice-cream-cone program is old stuff to others. In Bedford, Ind., for instance, M.D.s have "prescribed" about 26,000 scoops of ice cream in the last six years. Bedford doctors hand the small fry a "prescription blank"—to be filled at a drugstore soda fountain. [MORE→



Rx FOR PLEASURE is this ice cream award, which helps many physicians win small friends and influence parents.



'HEALTHY SKEPTICISM' will help a doctor decide between the miracle cures and the duds, says William H. Oatway Jr.

And the Bedford practitioners don't even have to pay for the cream; a local dairy foots the bills (about \$250 a year covers prescription blanks as well as cones). The dairy is happy because of the promotional value of the arrangement; doctors are pleased because it helps them deal with the younger set; and the kids—well, they like ice cream.

Find 20 Per Cent Waste In Blue Cross Use

"Some startling revelations" have been made by a committee of Michigan physicians sifting through Blue Cross cases for signs of abuse. Most shocking discovery, according to the

state medical society: One insurance dollar in five is apparently wasted.

The investigating doctors turned up such typical cases as the following:

¶ A patient is "hospitalized over the week-end . . . so [his] family can take a trip" without being burdened by him.

¶ A patient is kept in a hospital bed an extra day or two "in order to hold a bed . . . for another of the doctor's patients."

¶ An individual hospitalized for a wrist fracture is given "every blood and serological test, as well as gastrointestinal series."

Such abuses may ultimately force the insurance plans out of business, warns an editorial in the Michigan society's journal. "And," it adds sadly, "all this is so unnecessary."

Tells M.D.s: 'Be Chary Of New Cures'

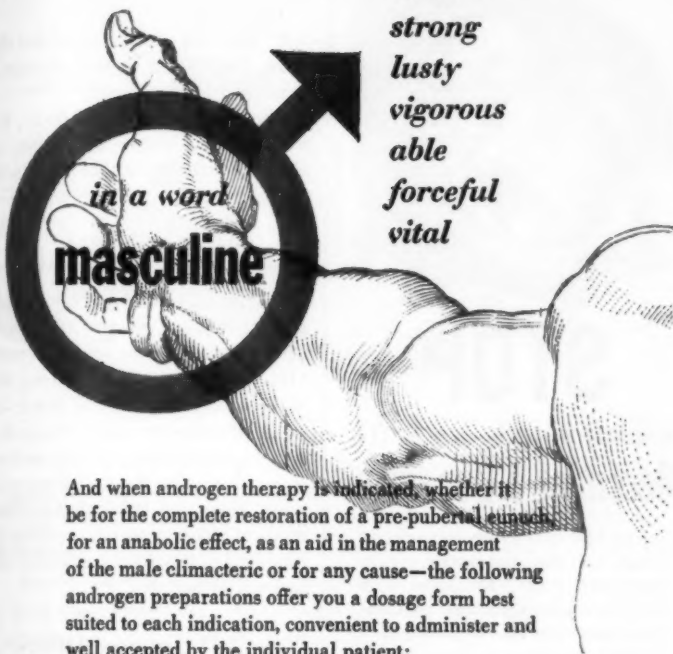
Since "we have medical miracles popping up as frequently as new moons," the doctor must maintain a "healthy skepticism." In fact, says Dr. William H. Oatway Jr., writing in *Arizona Medicine*, the M.D. should take such mental steps as the following before embracing any new "medical discovery":

¶ "Consider the source of the report."

¶ "Think back on the history of the [development]. Is it logical?"

¶ "Ask an authority for an opinion."

[MORE→]



*virile
strong
lusty
vigorous
able
forceful
vital*

And when androgen therapy is indicated, whether it be for the complete restoration of a pre-pubertal eunuch, for an anabolic effect, as an aid in the management of the male climacteric or for any cause—the following androgen preparations offer you a dosage form best suited to each indication, convenient to administer and well accepted by the individual patient:

SYNANDROL

* brand of testosterone propionate in sesame oil: 25 mg., 50 mg. and 100 mg./cc. in 10 cc. multiple-dose vials and in single-dose Steraject® disposable cartridges.

SYNANDROL*-F

brand of testosterone in aqueous suspension: 25 mg., 50 mg. and 100 mg./cc. in 10 cc. vials.

SYNANDROTABS*

brand of methyltestosterone tablets, for oral use: 10 mg. and 25 mg., bottles of 25 and 100.

SYNANDRETS*

brand of testosterone transmuscular tablets, for absorption by the transmuscular route: 10 mg., bottles of 25 and 100; 25 mg., bottles of 25.

Pfizer SYNTAX PRODUCTS

®TRADEMARK



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Division, Chas. Pfizer & Co., Inc.



STOP

useless cough . . . write
Mercodol c̄ Decapryn

Stops the tiresome, wracking cough, but does not interfere with the cough reflex. Mercodol with Decapryn controls cough by these important actions: 1. Antitussive 2. Bronchodilator 3. Expectorant 4. Antihistamine for added relief of the allergic cough. You'll see several coughing patients this week. Prescribe the cough syrup that really works and *tastes good*. Write Mercodol with Decapryn. One teaspoonful every 3-4 hours.

Mercodol c̄ Decapryn

(for relief of the allergic cough)

Mercodol (Plain)

(Triple-action antitussive also available)

PIONEER IN MEDICINE FOR 125 YEARS



New York CINCINNATI St. Thomas, Ont.

Trademark 'Decapryn' Mercodol®

278

MEDICAL ECONOMICS · MARCH 1954

NEWS

¶ "Decide on the need for the item. Is it urgent enough to take a chance?"

Above all, says Dr. Oatway, it's wiser to be "conservative than to play the lead in 'Gullible's Travels' or 'Dr. Alice in Wonderland.'"

Army Study Plan Pays

The graduate training program begun for medical officers seven years ago is showing fine results, reports Maj. Gen. George E. Armstrong, the Army's Surgeon General. Proof: In 1945, there were just seventy-five board specialists in the service. Now, thanks to the residency program, there are 466 board-certified medical officers on duty; and they're qualified in nineteen specialties and subspecialties.

New G.P. Journal Offers Boiled-Down Reading

Still another medical journal—this one called Q.S. (for Quantum Sufficit) Digest—is slated to make its debut next month as a ninety-six-page, pocket-size boon to general practitioners.

On the theory that the average family doctor hasn't time to read all the medical literature he'd like to, Q.S. Digest's co-editors—Drs. Harold J. Harris of New York City and Paul L. Wermer of Chicago—plan to scan some 300 journals every month and to print the meat of the clinical articles most important to G.P.s.

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looks good

tastes good

is good!



Children find Mulcin so delicious that they're always eager for more. Good-tasting Mulcin supplies well balanced amounts of all vitamins for which Recommended Daily Allowances have been established.

Tempting Mulcin has all the rich flavor and aroma of real orange juice. There's no need to coax even finicky children to take Mulcin. Free-flowing, easy-to-pour Mulcin does not separate and requires no shaking. For infants, Mulcin mixes easily with formulas or other foods.

With Mulcin, refrigeration is unnecessary. Specially safeguarded stability assures the full potency you prescribe.

Each teaspoon of Mulcin supplies:

Vitamin A	3000 units
Vitamin D	1000 units
Ascorbic acid	50 mg.
Thiamine	1 mg.
Riboflavin	1.2 mg.
Niacinamide	8 mg.

In 4 ounce and economical 16 ounce bottles.

Mulcin puts a smile in the vitamin spoon

Mulcin

the orange-flavored multivitamin liquid



MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA, U.S.A.

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the
Plus
 needed
 for complete
 anemia
 therapy

Heptuna[®] Plus

a vitamin-mineral
 formulation
 rich in iron,
 vitamin B₁₂
 and folic acid



each capsule of

Heptuna Plus

contains:

Ferrous Sulfate U.S.P.	45 g
Vitamin B ₁₂	5 mcg
Folic Acid	0.30 mg
Ascorbic Acid	50 mg
Vitamin A	5,000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Thiamine Hydrochloride	2 mg
Riboflavin	2 mg
Pyridoxine Hydrochloride	0.1 mg
Niacinamide	10 mg
Calcium Pantothenate	0.25 mg
Cobalt	0.1 mg
Copper	1 mcg
Molybdenum	0.2 mcg
Calcium	37.4 mg
Iodine	0.05 mcg
Manganese	0.053 mg
Magnesium	2 mg
Phosphorus	20 mg
Potassium	1.7 mg
Zinc	0.4 mg

With other B-Complex Factors from Livo.



J. B. ROERIG AND COMPANY, Chicago 11, Illinois

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The magazine is being published at Ramsey, N.J., and will be sent free to all general practitioners under 65. Its lawyer-publisher, Judge M. N. Scharf, hopes eventually to include internists on the subscription list.

New Slant for Schools

American medical schools place too much emphasis on building a better curriculum and not enough on "selecting students who will become good physicians," says Dr. Alfred Washburn, professor of pediatrics at the Colorado School of Medicine. So he recommends that the schools sponsor research projects in order to learn more about the characteristics that make for the best medical students and doctors. After all, Dr. Washburn points out, the best course of study in the world won't help a student who isn't cut out to be a doctor in the first place.

Syphilis Found Making A Strong Comeback

'Doctor-government cooperation needed to combat it'

There's been talk that, thanks to penicillin, syphilology is dead as a medical specialty; but venereal disease figures for fiscal 1953 suggest that any such talk is premature. The current V.D. picture, in a nutshell:

In fifteen states and the District of Columbia, the incidence of syphi-



M.D.s ARE RESPONSIBLE, along with Government agencies, for the rise in the incidence of syphilis in one-third of the U.S., charges Charles R. Rein.

lis has apparently increased. Highest rate in the U.S. is that of Washington, D.C., with 463 cases per 100,000 persons. Steepest rate climb turns up in New Orleans: from 207 cases per 100,000 persons in 1952 to 332 per 100,000 last year.

What accounts for the spurt in the incidence of this supposedly licked disease? Government agencies and individual physicians must share the blame, according to Dr. Charles R. Rein of New York University.

Federal, state, and local authorities have made "repeated, drastic cuts" in their appropriations for V.D. control activities, he points

**WHEN TREATMENT
IS INDICATED —**

RECOMMEND  **To**

Discourage

NAIL-BITING

**PAINT ON
FINGERTIPS**

**USE THUM IN STUBBORN
THUMB-SUCKING CASES TOO**



**50c and \$1.00 ORDER FROM YOUR
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out; and continued retrenchment appears in prospect. So he finds the outlook dim for any government attack on the problem—especially as regards “the nation’s reservoir of untreated syphilis . . . estimated at 12 million cases.”

Where individual physicians fail down, continues Dr. Rein, is in relying so heavily on penicillin therapy that they’ve been “lulled into a false sense of security.” Any hope of knocking out syphilis, he says, must depend on the average doctor’s raising his “index of suspicion” about the disease and cooperating closely with health officials.

‘You Protect Us,’ Says Blue Cross Official

If voluntary health insurance is to remain healthy, patients and doctors alike must learn some important lessons, says James H. Smith, executive director of the Hospital Service Association of Toledo, Ohio. So he suggests these homework assignments:

¶ Each patient should learn that insurance doesn’t provide “something for nothing . . . Every time a Blue Cross member goes to a hospital, it costs every other member money.”

¶ Each physician should remember that, while there are laws against arson to protect fire insurance, there’s no such law against misuse of Blue Cross. The doctor himself is “the only protector.” He determines the cost of an illness (and thus the price of health insurance), since it’s “he

not an estrogen but not anti-estrogenic

Today caution surrounds the indiscriminate use of estrogenic hormone therapy—the consensus being that it should be used only in endocrine deficiency.

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who says when the patient goes to the hospital, what he is to be given in the hospital, and when he is ready to leave the hospital."

Test Devised to Guide Would-Be Specialists

Do you prefer poker to bridge? Did you get into many fights in grade school? On a train trip, would you prefer talking to a banker, an artist, or a reporter?

These are meaningful questions to psychologists Edward K. Strong Jr., professor emeritus of Stanford University, and Anthony C. Tucker of the Army Medical Service Corps. By confronting a young doctor with 171 such queries, they believe they

can determine whether he will enjoy specializing in one of four fields—surgery, internal medicine, pathology, or psychiatry.

The test was developed with the aid of a \$50,000 Army grant and advice from over 4,000 practicing physicians. The Army, of course, feels that the test may eventually pay for itself if it indicates whether time and money should be spent in training given doctors as specialists. And young physicians themselves have perhaps an even greater stake in it.

Professor Strong emphasizes, however, that the test won't reveal the aptitude of the person answering the questions. Instead, it aims to show the extent to which "his interests agree with the interests of successful

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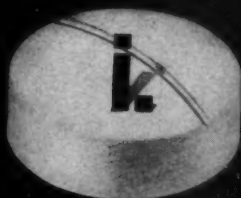
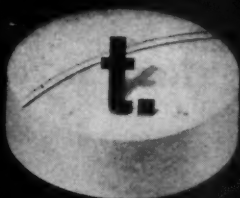
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Free with $\frac{1}{8}$ gr. Phenobarbital**



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men already practicing" certain specialties. Within this limitation, Strong and Tucker hope to broaden the scope of their test so that it will cover all medical specialties.

Tycoon Gives Profits To Medical Research

Industrialist Howard Hughes, who is best known for his airplanes and movies, is taking a flier in medicine—his second.

The West Coast millionaire has announced the formation of a non-profit foundation for medical research, to be supported by profits from the Hughes Aircraft Company. Personnel of the foundation, which will be known as the Howard Hughes Medical Institute, may include men who benefited from Hughes' first philanthropic venture into the medical field—research scholarships he set up in 1951.

Patients Urged to Be Honest With M.D.s

That troublesome patient, the fibber, has been told off in a recent article in the magazine *This Week*. "Don't try to fool your doctor"; it only wastes time, money, and health, says the writer, Dr. A. Wilbur Duryee. And, to explain what he means, he cites three ways in which some patients habitually practice deception:

1 "At one extreme is the patient who is really sick, but who . . . won't

admit it . . . He will only give in to medical care when he is on the verge of a complete collapse." And even then, he may simply pretend to follow orders. Dr. Duryee tells, for example, of an elderly woman who failed to respond to treatment at home and was finally taken off to the hospital. Then "her family found just about every pill the doctor had



HIGH FLIER Howard Hughes (shown here with movie star Ava Gardner) is plunging some of his bankroll into medical research.



For those who cannot or should not climb stairs, Sedgwick offers Stair-Travelors and Residence Elevators (see sketch below) to eliminate the danger of over-exertion. Sedgwick equipment is quickly and easily installed. Safe, dependable and inexpensively operated on ordinary house current. Nationwide representation.

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prescribed for her stashed neatly away under the mattress of her bed.

¶ At the other extreme are the hypochondriacs who "bombard their doctors with long lists of mythical symptoms for non-existent ills." Such patients, says Duryee, will even resort to the shopworn trick of rubbing the thermometer "to boost [its] reading up into the fever zone."

¶ And, of course, there are the many individuals who merely tell little lies; they minimize the extent of "their indulgences—the foods they eat, the number of drinks they consume a day, the number of cigarettes they smoke."

But even the very small fib sets up a roadblock for the physician, says Dr. Duryee. "No doctor," he points out, "enjoys playing medical truth or consequences."

Advises Auto Buyers to Check Finance Deals

If you're thinking of making time-payments on a new car, you'll do well to shop around before signing a financing contract. Big car-financing companies, like the General Motors Acceptance Corporation, handle the bulk of such business, of course; but it's often possible that you'll do better with smaller firms, credit unions, or banks, says *Changing Times*, The Kiplinger Magazine.

Take the banks, for instance: They're "more rigid than other money lenders about terms and down payments." But, says the magazine, their interest rates are likely to be

What's so *different* about the Viso-Cardiette?

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What about Cobalt?

—in anemia—

Q. Why is Roncovite* effective in anemias of bone marrow depression due to infection or disease?

A. Because cobalt is the only agent known which, by stimulating erythropoiesis, will cause the hemopoietic system to utilize the iron already available to it.

Q. Why use cobalt in iron-deficiency anemia— isn't iron alone adequate?

A. Roncovite is preferentially indicated in ALL forms of "secondary" or iron-deficiency anemia for the following reasons:

Many so-called iron-deficiency anemias are in reality a combination of an iron-deficiency and an inhibition of hemopoiesis *resulting from long continued extra drain on the bone marrow.*

With iron alone,¹ therefore, a complete clinical response is often difficult or impossible to obtain—only very small gains or poor responses being frequently reported in "low-grade anemias."

Roncovite, by providing the added bone marrow (red cell) stimulant action of cobalt, will supply that added extra "push" to mobilize iron reserves, produce a faster response, greatly superior erythropoiesis and up to fourfold increases in the utilization of iron.²

Q. Why is iron present in Roncovite?

A. The increased hemopoiesis from the specific bone marrow stimulant action of cobalt often creates a need for additional iron to make hemoglobin for the new red cells—Roncovite provides iron to fill this need and to maintain iron reserves.

Q. Can I be sure that cobalt is safe for routine use?

A. Cobalt is an essential element with a low order of toxicity—no greater than that of iron. A cobalt chlor-

ide dosage of as high as 1200 mg. per day, in divided doses, has produced no severe toxic effects even if continued for six weeks.³ This is equivalent to a daily dosage of over 80 Roncovite tablets.

Q. Is cobalt cumulative?

A. No—extensive pharmacological investigation proves that cobalt is rapidly and almost completely excreted via the urine⁴ so that there is little if any cumulative effect even after periods exceeding 100 days of continuous parenteral use. The body shows no significant amounts of cobalt 48 hours after the last dose.⁴

Q. Is the improvement with Roncovite noticeably rapid?

A. Yes—the patient often voluntarily reports an increased sense of well-being within a few days—as reported by documented clinical evidence.

Roncovite is not indicated in pernicious or megaloblastic anemia.

HOW SUPPLIED:

Roncovite Tablets —enteric coated, red, each contains cobalt chloride 15 mg.; exsiccated ferrous sulfate, 0.2 Gm.; bottles of 100. Dose: One tablet 4 times a day.

Roncovite Drops —each 0.6 cc. contains cobalt chloride, 40 mg.; ferrous sulfate, 75 mg.; bottles of 15 cc. with calibrated dropper. Dose: 0.6 cc. daily.

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The First True Hematopoietic Stimulant

1. Cass, L. J.; Frederick, W. S., and DiGregario, S.: *Journal-Lancet* 51:73 (1953).
2. Rohn, R. J., and Bond, W. H.: *Journal-Lancet* 73:317 (1953).
3. Berk, W., et al.: *New England J. M.* 240:754 (May) 1949.
4. Berlin, N. I.: *J. Biol. Chem.* 187:41 (1950).

*The original Cobalt-Iron Product.

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NEWS

comparatively low—"as low as 38 to 5 per cent, discounted, on new cars."

Naturally, it adds, the kind of financing *you* can arrange depends in part on the type of car you buy. You can usually get better terms on a popular make than on an off-brand or unpopular model (such as a wooden station wagon).

Travel-Fund Cuts Worry Federal M.D.s

*They protest economy measure
as being too sweeping*

Doctors in the U.S. Public Health Service aren't getting around much any more; and they're unhappy about it. As recently as fiscal 1951, they had a travel budget of \$125,000—enough to send wholesale lots of them from Bethesda, Md., and Washington to various conventions around the country. But in the current fiscal year, the Eisenhower economy drive has slashed the Service's go-to-meeting budget to just \$42,200.

As a result:

¶ Where the National Institutes of Health—research arm of the Service—sent thirty of its top men to the 1952 meeting of the American Chemical Society, it dispatched only five to the most recent meeting.

¶ Where thirty P.H.S. men attended an A.M.A. convention in 1952, only three had their bills paid by the Government last year.

¶ Where almost 100 delegates were sent to the 1952 session of the

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pancreatin	126 mg.
pepsin	126 mg.
Betaine Monohydrate	200 mg.
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Vitamin B ₁₂	4 mcg.
Inositol	100 mg.
Thiamine HCl (B ₁)	4 mg.
Riboflavin (B ₂)	2 mg.
Pyridoxine HCl (B ₆)	2 mg.
Panthenol	2 mg.
Niacinamide	20 mg.
Calcium Glycerophosphate	300 mg.
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to enhance appetite, promote digestion
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secretions, digestion, elimination,
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TIME FOR A CHANGE in lay medical writing, according to Edith M. Stern. She'd like an end to loose talk about new cures.

American Public Health Association, only about half as many got free passage last year.

Such travel cuts disturb M.D.s of the Department of Health, Education, and Welfare, who feel that Congress went too far. Says one disgruntled doctor: "It's an important part of our work to get out of Washington and consult with our colleagues." He points out, incidentally, that numerous Government medical men have been traveling to recent conventions at their own expense.

Of course, he adds, most members of the Department think it right for Congress to "tighten the purse strings and prevent travel by regi-

ments." But he concludes, a little wistfully: "We hope that Congress will be a bit more generous next year and provide for travel by companies, not just platoons."

Writer Doubts Value of Lay Medical Articles

Says magazines raise 'false hopes' in patients

A veteran writer of lay-magazine medical articles, Edith M. Stern, has let her hair down. "I don't like popularization [of medical subjects]," she admits. "It has gone too far."

In an article in *The Saturday Review*, Miss Stern says she's weary of seeing "false hopes inspired by medical articles with such recurring titles as 'There's Hope for . . . ' and 'Good News About . . . ' Far from helping patients, she adds, this sort of thing simply makes the doctor's task all the more difficult. For example:

¶ Thanks to loose talk about wondrous cures, the physician finds that "scarcely a day goes by . . . that some patient's relative . . . doesn't brandish a magazine article and demand accusingly, 'Why haven't you used this treatment?' The [doctor's] explanation, 'It's not indicated,' is pale and unsatisfactory beside the glowing promise in the printed words."

¶ As a result of articles on breast cancer, many women examine themselves instead of going to their physicians. In fact, Miss Stern tells of a

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SALIMEPH-C, a new synergistic combination of mephenesin and salicylamide, successfully combats the interrelated pain and spasm of arthritis, myositis, bursitis, spondylitis, and low-back pain by providing:

SUSTAINED MUSCLE RELAXATION: in a new clinical study¹ of 200 unselected cases of arthritic and myositic conditions with associated pain and skeletal muscle spasm, **SALIMEPH-C** definitely gave effective relief from pain and spasm often after other forms of therapy including ACTH and Cortisone had failed.

MAXIMUM SAFE ANALGESIA: use of salicylamide in **SALIMEPH-C** provides desired analgesia at a lower drug level² and is better tolerated than acid-forming salicylates.^{3,4} Optimum vitamin C levels are assured by the addition of ascorbic acid.

REFERENCES: 1. Natenshon, A. L., Wisconsin M. J., in press.
2. Seeborg, V. P., et al.: J. Pharmacol. & Exper. Therap. 101:275, 1961. 3. Brodie, D. C., and Szekely, I. J.: J. Am. Pharm. Ass., Scient. Ed. 40:414, 1951. 4. Wegmann, T.: Schweiz. med. Wchnschr. 80:62, 1950.

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NEWS

Government official who was puzzled by the conduct of the women in his office. "They go about all day long pinching their breasts," he said.

There's only one possible cure for the magazines' tendency to turn medical molehills into mountains of circulation, as Miss Stern sees it: "gentlemen's agreements among [publishers, editors, and writers] never again to . . . fan cool facts into hot news." With such pacts in force, she maintains, "we would sleep better!"

This Doctor Eyes Seat Of the Problem

Here's ammunition for those who say a physician must take an interest in the whole patient, not merely his disease:

In Ironton, Ohio, 6-year-old Johnny Earhart recently told his parents he couldn't see the blackboard in school. Alarmed, they rushed him to Dr. John A. Dole Jr., whose careful examination of the boy's eyes disclosed nothing wrong. Puzzled, Dr. Dole asked the little fellow: "Why can't you see the blackboard?"

Answered Johnny: "Because there's a big boy sitting right in front of me."

Health Insurance Firm Gives Lesson in Logic

Is there a solid basis for the fairly common complaint that service-type health insurance reduces the doctor's income by converting paying

patients into insurance patients? Definitely not, says Group Health Insurance, Inc., a company operating in the New York metropolitan area.

It explains that it provides complete medical-surgical service benefits for subscribers who accept semi-private hospital accommodations, and that most members naturally accept such care. But a company survey shows that almost 12 per cent of G.H.I. subscribers prefer private hospital rooms, thus permitting doctors to charge better than G.H.I. rates.

This is particularly significant, adds the insurance firm, since its subscribers have a generally lower income than the public at large—only about 10 per cent of whom use private hospital rooms. Thus, it contends, its own health insurance, at least, encourages patients to buy “more expensive medical services—not less.”

Are Radio-TV ‘Doctors’ On Their Way Out?

One of broadcasting’s best-known characters—the “physician” who spouts “medical” claims without benefit of a medical degree—has suffered a severe blow in recent months. There’s some doubt that he’ll recover.

As a partial result of A.M.A. pressure, the networks have been insisting that endorsements delivered by make-believe M.D.s be clearly labeled “medical dramatizations.” And at least one advertiser has de-

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Erythrosulfa

in refractory or
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ERYTHROMYCIN

the antibiotic of choice
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to cover Gram-negative bacteria
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Erythromycin	100 mg.
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NOW... Better assimilation of calcium in the diet of pregnancy!

A report of a significant clinical study

Recently investigators have agreed that maximum assimilation of calcium in the prenatal diet can be achieved through use of a phosphorus-free form of calcium. Now further proof of this concept is available through the work of Gross, Wager and Loving,* who conducted a series of biochemical determinations following the use of CALCISALIN, and compared them with the findings from two control groups. A portion of the results is shown in the following:

	Patients receiving Calcisalin and reporting neuro-muscular complaints			Control Group A No prenatal supplement	Control Group B Dicalcium Phosphate supplement
	Initial Value (mg. per 100 ml.)	After 4 weeks (mg. per 100 ml.)	Per Cent Change	Per Cent Change	Per Cent Change
Total Calcium	8.89	10.70	+17.0	-8.0	-3.5
Inorganic Phosphorus	4.08	3.21	-22.0	+3.5	+6.0
Total Protein	6.65	6.70	+1.0	+4.5	-1.0
Calculated Ionic Calcium	4.10	5.0	+18.0	-6.0	-0.9
Ratio: Ionic Calcium Phosphorus	1.09	1.55	+35.0	-11.0	-7.0

*CALCIUM METABOLISM IN PREGNANCY, Gross, M., Wager, H. P., Loving, M., Bulletin of the Margaret Hague Maternity Hospital, Dec. 1953. (From the department of Biochemistry, Margaret Hague Maternity Hospital, J. C., N. J.)

Calcisalin®

incorporates a new principle in prenatal supplementation. In it calcium lactate replaces dicalcium phosphate; aluminum hydroxide gel removes excess dietary phosphorus from the intestinal tract; iron and vitamins are included according to recommendations of the National Research Council. To help you make your own evaluation of Calcisalin we will send, on request, a file of literature including a reprint of the study above, and a supply of samples.

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cided to jettison its "doctor" rather than comply: Colgate-Palmolive now discreetly calls its broadcasting man in white a "laboratory technician."

Proposes Private Care For Future Veterans

Washington is currently writing off Universal Military Training as a dormant duck; but if it ever comes to life, it's likely to embody these proposals, made recently by President Eisenhower's National Security Training Commission:

1. Regular Selective Service doctors would give pre-induction examinations.

2. During the training period, enrollees would get care from military medical officers in the usual manner.

3. Once out of service, U.M.T. veterans would *not* be eligible for Veterans Administration medical benefits. Instead, they'd have to accept private care; but they'd come under the Federal Employees Compensation Act for payment of costs linked to service-connected ailments. (This proposal is similar to one made by the A.M.A.)

M.D.'s Leaflet Answers Surgery-Fee Queries

What can the average doctor do to counteract the bad publicity given the profession by widely read articles on fee splitting? Here's one G.P.'s answer—a pamphlet that at-



DOWN IN WRITING: To help surgical patients figure fees in advance, Walter L. Porteus gives them a detailed pamphlet.

tempts to explain fees to patients about to undergo surgery.

The brainchild of Dr. Walter L. Porteus, president-elect of the Indiana State Medical Society, it points out that an operation will require the services of "a team of highly trained specialists . . . Not only will I, as your physician, be in attendance, but also a surgeon, an anesthetist, several nurses, and in some cases an assisting surgeon." And it emphasizes three facts:

1. While all this may entail added expense, it's "for your protection."

2. Bills "will in most cases be rendered by individual members of the team."

3. Hospital charges will cover

↓ skin troubles?

Marcelle Hypo-Allergenic Cosmetics were designed for the woman who needs something different from the average. Thousands of women with cosmetic or skin problems have found these delicately compounded beauty preparations notably safe even for sensitive skins because known irritants have been eliminated from Marcelle Cosmetics.

Marcelle's entire line of more than 40 different beauty preparations in a complete range of high fashion shades is available in either scented or unscented form.

The original Hypo-Allergenic Cosmetics. First to be accepted by the Committee on Cosmetics of the American Medical Association.

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NEWS

only hospital services, materials used, and appliances furnished, not the doctors' fees.

For his part, Dr. Porteus offers to help by making an advance estimate of total costs. And he advises the patient to study his insurance plan, so that he'll know in advance how much of the final bill it will cover.

Hospital Chiefs Oppose Dependent-Care Plan

If the armed forces put through their program for broadening care of G.I. dependents, warns the American Hospital Association, the U.S. may have to build an expensive and unnecessary chain of military hospitals.

To guard against such an eventuality, leaders of the A.H.A. have joined top medical men in recommending that Blue Cross-Blue Shield coverage be extended to soldiers wives and children. In this way, says the association, they'd be assured "the privilege of free choice of hospital and physician."

Lists Ways to Finance House Expansion

Kiplinger calls attention to four possible sources of money

If you're outgrowing the house that once seemed so roomy, you may be considering an addition to it. The question of raising the money for any such project is discussed in a recent article in *Changing Times*,

Electrifying Announcement!



For 21 years, IBM has been making the finest typewriters in the world! And now two new model IBM Electrics are ready for you—the new Standard and the new Executive*!

These new IBM's have exciting new features never before available on *any* typewriter! And the work *anyone* can turn out is so fine that every letter is a masterpiece of typing!

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Dispersible { per teaspoonful
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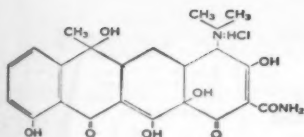
Other dosage forms will become available as rapidly as research permits.

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The Kiplinger Magazine, which suggests four alternatives to out-of-pocket financing:

1. *Dealer credit.* Your building-materials dealer offers both short-term credit and "longer installment plans with a carrying charge." Chief drawback: "The credit extends only to materials, not to labor."

2. *F.H.A.-insured loans.* These are available for any improvement that "becomes a permanent part of the building . . . [But] the most you can borrow the F.H.A. way is \$2,500, repayable within three years." And such loans are expensive, since they're "made in the form of notes discounted at rates up to \$5 per \$100 per year. That's equal to over 9 per cent interest."

3. *Refinancing.* This is perhaps the best way to finance any really elaborate—and costly—expansion. It entails taking out a new mortgage and using "part of the proceeds to retire the old mortgage and the rest for expanding."

4. *Open-end mortgaging.* If you're one of the relatively few homeowners who have this form of mortgage, you can borrow money from the lender for improvements after "you have paid back a stated minimum portion of your original loan."

Of course, financing isn't the only problem encountered in house-expansion. So the magazine passes along these additional tips:

¶ Finishing off an attic or a basement is usually cheaper than adding

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AQUACHLORAL SUPPRETTES have won instant acceptance by the Profession. Being formulated in the new and exclusive water-soluble base, NEOCERA, no refrigeration is required. Not irritating to the rectal mucosa. No discomfort or leak-back after insertion. Uniform solubility assures uniform absorption.

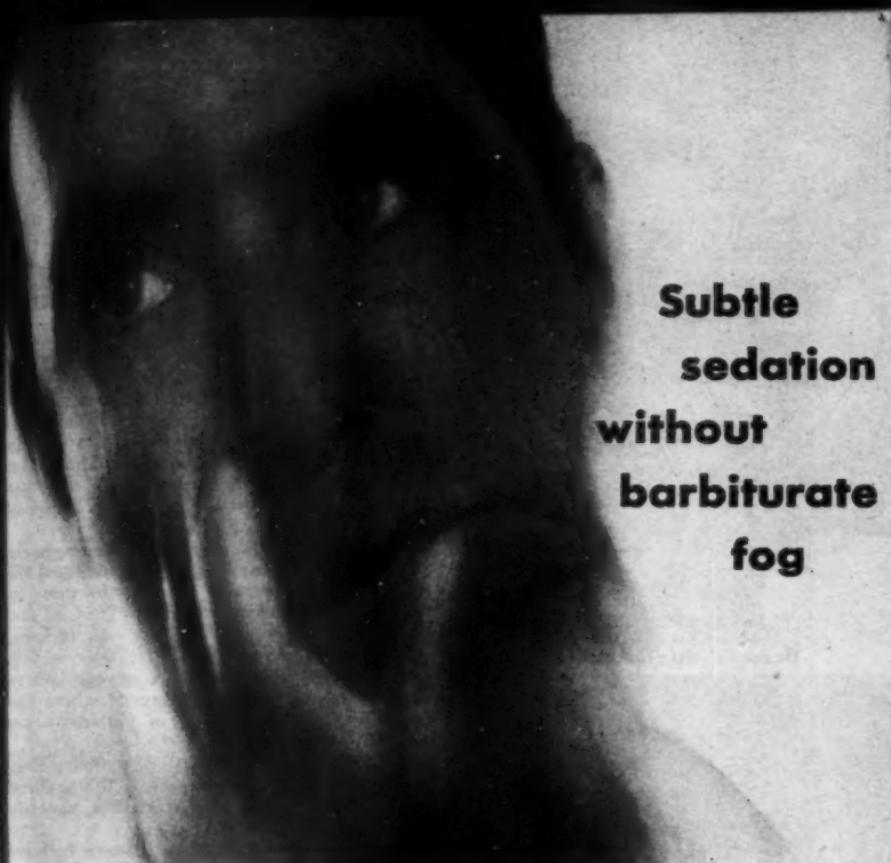
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Sedamyl,® the non-barbiturate daytime sedative, reduced anxiety in 90 per cent of 333 anxious, nervous patients.¹ Sedamyl calms and tranquilizes but does not bring on cerebral fog—does not dull perception. Sedamyl lets the patient go at his day's work fully alert yet nicely protected from excessive anxiety and tension. Sedamyl is sure to be an "unusually safe and practical"¹ sedative for the anxiety-ridden patients you see day after day.

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acetylbromdiethylacetylcarbamid, Schenley.

1. Tebrock, H. E.: M. Times 79:760, 1951.



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After Use of Riasol

a better prognosis in PSORIASIS

It is safe to say that psoriasis is one of the most resistant of all skin diseases. In 1946, Shields¹ write that "psoriasis is incurable but does not affect the patient's general health." According to Schonberger² "certain cases of psoriasis will not be influenced by therapy of any kind." In 1946, Ormsby and Montgomery³ state that "permanent relief should be neither promised nor predicted in any case."

In view of this general discouragement, the highly satisfactory results obtained with RIASOL in psoriasis are all the more impressive: improvement in 76% of all cases in a controlled clinical group, including complete clearing of the lesions in 38%. In a series of 231 cases of psoriasis reported by two dermatologists, there were only 16.5% remissions in patients treated by other methods.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fl. oz. bottles at pharmacies or direct.

1. J.A.M.A. 140:768, 1949. 2. Ohio State M. J. 4:50, 1946. 3. Diseases of the Skin, 1943, p. 291.

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RIASOL FOR PSORIASIS

XUM

in wing, since "there's no new roof to buy and no new foundation to build."

¶ Before taking the final step,

you'll do well to consider the condition of your house and of your neighborhood. If either "is becoming decrepit . . . think twice before you

Medical Meetings in Europe

If you plan to mix business with a pleasure trip to Europe, you'll find a wide choice of meetings scheduled. Here's the list:

April 21-25. PARIS. Journées Médicales. Organized by the Medical Societies of France.

April 27-30. SCARBOROUGH, ENGLAND. Health Congress of the Royal Sanitary Institute.

May 4. GENEVA. Seventh Meeting of the World Health Assembly.

May 8-16. DUBROVNIK, YUGOSLAVIA. International Congress of Hydroclimatism and Thalassotherapy.

May 13-15. LEEDS, ENGLAND. Association of Surgeons of Great Britain and Ireland.

May 17-19. LONDON. Sectional Meeting of the American College of Surgeons.

May 19-22. BELGRADE. Tenth International Congress of Athletic Medicine.

May 21-22. PARIS. Congress of the International Society of Surgery.

May 29-June 6. TURIN, ITALY. Second International Medico-Surgical Reunion and International Fair of the Sanitary Arts.

June 26-July 2. PARIS. Fourth Congress of the European and Mediterranean Union of Gastroenterology.

June 30-July 4. DUBLIN. World Congress of Catholic Doctors.

July 1-9. GLASGOW. Annual Representative and Scientific Meetings of the British Medical Association.

July 9-10. EDINBURGH. Meeting of European Society of Cardiovascular Surgery.

July 19-23. LONDON and OXFORD. Third International Congress of Gerontology.

July 21-24. ZURICH. International Congress for Psychotherapy.

July 26-31. GENEVA. International Congress of Gynecology and Obstetrics.

Aug. 17. EDINBURGH. World Federation of Occupation Therapists.

Aug. 23-28. AMSTERDAM. International Congress of Photobiology.

Aug. 29-Sept. 5. LAKE GARDA, ITALY.

Eighth Congress of Medical Women's International Association.

Aug. 30-Sept. 3. BERNE, SWITZERLAND. Sixth Congress of the International Society of Orthopedic Surgery and Traumatology.

Aug. 30-Sept. 18. ROME. World Population Conference (under the auspices of the United Nations).

Sept. 1-8. OXFORD. Annual Meeting of the British Association for the Advancement of Science.

Sept. 2-9. LEYDEN, HOLLAND. Eighth Congress of the International Society for Cell Biology.

Sept. 6-10. ROME. Third International Poliomyelitis Conference.

Sept. 6-11. PARIS. Fourth Congress of the International Society of Hematology.

Sept. 12-19. PARIS. Fifth International Congress of Blood Transfusion.

Sept. 13-17. THE HAGUE. Sixth World Congress of the International Society for the Welfare of Cripples.

Sept. 13-19. NAPLES. Eleventh International Congress of Industrial Medicine.

Sept. 13-20. ROME and SALERNO. Fourteenth International Congress of the History of Medicine.

Sept. 14-18. AMSTERDAM. Third International Congress of Nutrition.

Sept. 15-18. STOCKHOLM. Third International Congress of Internal Medicine.

Sept. 26. VICHY and PARIS. Congress of the International Society of Medical Hydrology.

Sept. 26-Oct. 2. ROME. Eighth General Assembly of the World Medical Association.

Sept. 26-Oct. 2. MADRID. Thirteenth Conference of the International Union Against Tuberculosis.

Oct. 4-8. BARCELONA. Third International Congress on Diseases of the Chest.

Oct. 10-13. LISBON. Third International Congress of Bronchoesophagology.

sink more money into a property that soon may be worth less than it cost."

¶ If you're planning anything more elaborate than finishing off an attic or basement, you may want to hire an architect. Not only will he help you work out the design, but he can "steer you through the building code, select good, cheap materials, help you get bids from reliable contractors, and see the job through."

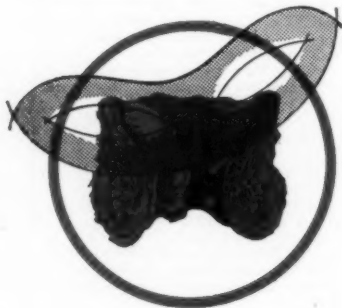
For Women Only?

Wheel-coming-full-circle department: The armed forces may one day utilize men to make up a shortage of women. At least, that's the purpose of a new bill (S. 2671) in-

troduced by Senator Irving Ives (R., N.Y.); it would authorize commissions for male nurses. The idea has been proposed before, but service resistance has kept it from becoming law.

Medical Emergency: Too Many Medical Men

Can you picture 30,000 physicians unable to find openings in medicine? That happens to be a true picture of West Germany today, according to a recent study by Reuters, the British news agency. Responsible are a variety of postwar factors, including a tremendous influx of refugee doctors from East Germany and other parts of Europe. [MORE→]



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P.S. Doctor, you ought to try Sanka Coffee yourself. It is wonderful coffee with a fine aroma and flavor.



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About 4,500 M.D.s are working as street-car conductors, mechanics, and laborers, says Reuters. Others keep in touch with medicine by holding no-pay or low-pay subprofessional jobs. And many are eying medical opportunities in doctor-short areas of Africa and the East.

M.D.s Said to Be Losing Their Individuality

Fortune article concludes that public misses old-time G.P.s

Why is the modern doctor the target of so much criticism? What accounts for the apparent paradox that "the more . . . successfully the physician treats patients, the less is his per-

sonal prestige"? One possible answer, according to writer Herryman Maurer: Medicine's technical advances have led patients to transfer their "uncritical awe" from the M.D. himself "to medicine in general."


While conceding that today's physician keeps more people healthy, many patients miss the "aura of mystery" that surrounded yesterday's family doctor, says Maurer. As a consequence—to quote the title of his article in the February, 1954, *Fortune*—"The M.D.s Are Off Their Pedestal."

The problem is rooted, he declares, in the fact that medicine seems to be becoming "stratified" because of overspecialization. Thus there's a danger that the "less-well-

purified


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STERIODS	Conjugated estrogens equine ("Permarin"®)	0.25 mg.
	Methyltestosterone	2.5 mg.
NUTRITIONAL SUPPLEMENTS	Thiamine HCl (B ₁)	5.0 mg.
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ANTIDEPRESSANT	d-Desoxyephedrine HCl	1.0 mg.
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"Mediatric" is specially formulated to meet the needs of the aging patient. It provides steroids to effectively counteract declining sex hormone function, vitamin factors to supplement the diet, and a mild antidepressant to promote a gentle emotional uplift.

No. 910 — Supplied in bottles of 16 fluidounces and 1 gallon.

Suggested Dosage: 3 teaspoonfuls daily, or as required.

*"Mediatric" Capsules, each equivalent to 3 teaspoonfuls of Liquid with added nutritional supplements. No. 252 — Bottles of 30, 100, and 1,000.

A dynamic approach to better health for the aging patient

NEW YORK, N. Y.  MONTREAL, CANADA

3419

313

CHOOSING A LAXATIVE

Chronic abuse of laxatives has increased over the years. Radio advertising, backyard talk and old people's tales about "poisonous wastes" have scared people into believing they are constipated.

A lot of folks are convinced they need a daily bowel movement. If they take a laxative, several days are normally required before bulk resulting in a bowel movement can accumulate. They think they are still constipated because no stool has passed. So—they continue the laxative treatment. Is it any wonder that the dosage—which always becomes stronger—eventually results in abnormal peristalsis and abdominal distress?

The Result

What can be expected from the continuous use of laxatives? Internal hemorrhoids, fissures, fistula or pruritus ani is not uncommon in patients suffering from long-term laxatives abuse.

Continued use of cascara may produce alterations in the bowel mucosa. Phenolphthalein has a mild irritant effect on the small intestine. Salines can produce dehydration. Mineral oil often interferes with absorption of fats and oil soluble vitamins, inhibiting intestinal motility. Enemas upset regular bowel action and have an irritating effect on the colon.

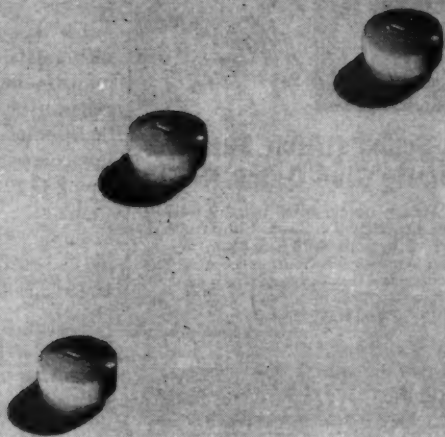
The Answer

With so many problems involved in the administration of ordinary laxative preparations, what can be done to relieve the discomforts of constipation? Doctors have found that bile—the normal laxative of the digestive tract—gives a smooth, unhurried evacuation. It is a natural method of stimulating peristalsis without habituation.



explosive or

"In acute constipation, the cathartic of choice is the...one which will produce a prompt and complete evacuation without excessive purgation." (Cornell Conference on Therapy, Vol. III, p. 279)



reaction... gentle evacuation?

"Bile has a *mild* laxative action ..." (U. S. Dispensatory, 24th edition: 808, 1947)

"... bile per se is stimulating to the movements of the bowel so that an increase in bile flow has a natural stimulating effect." (Shallenberger, P. L. and Kerr, P. B., Postgrad. Med. 13:32, 1953)

For deliberate, untroubled bowel action... try Doxychol-K. Each tablet contains Desoxycholic acid (1 gr.) and Ketocholanic acids (3 gr.). Doxychol-K is a product of Geo. A. Breon & Co., 1450 Broadway, New York 18, N. Y. Write today for samples.

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316

NEWS

trained" man in the U.S. may eventually "be relegated to the position he actually occupies under nationalized medicine in Britain."

The best chance of preventing such an eventuality, writes Maurer, probably lies in the efforts of many general practitioners to broaden their educational background. In this connection, he says that many young G.P.s, dissatisfied with their training, "are now going back to the teaching schools for standard training in . . . internal medicine and for added residencies in pediatrics and obstetrics."

Expansion Planned for 'Reading by Ear'

Just a year ago, Audio-Digest went into the business of helping physicians keep up with their reading by using their ears. For \$2.75 a week, G.P.s were offered hour-long, tape-recorded summaries of current lectures and literature, intended for leisure-hour or odd-moment listening. The idea caught on so well that within Audio-Digest's first few months, more than 3,000 doctors contracted to "read" while driving their cars or shaving in the morning.

Spurred by the G.P.s' response, the California Medical Association (whose public relations man, Jerry Pettis, originated the plan) has now taken over Audio-Digest as a subsidiary foundation. And it has widened the scope of the organization:

Special tape recordings are being offered to surgeons, obstetricians,



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samples and reprint¹
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70 Ship Street, Providence 2, R. I.

1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949.
4. Tuvell, R.: New York St. J. M. 50:2282, 1950.



and internists; and arrangements are being made to send summaries to medical officers overseas. All proceeds, the foundation announces, will go to the nation's medical schools.

Anonymous Physician Writes on Euthanasia

*Says it's often advisable—but
shouldn't be legalized*

Mercy killings can frequently be justified on humanitarian grounds, maintains the author of a recent article in Redbook. But as a doctor (for obvious reasons, anonymous), he hastens to assure his lay readers that the practice should *not* be given

legal sanction. The gist of his argument:

"Mercy killings will go on, whatever we try to do about it. Whenever there are doctors with feelings some of them will see it as their duty . . ." But as long as any such act is considered a crime, it will "rarely be performed for any reason other than to grant a suffering patient and suffering relatives a merciful end to their misery."

Legalization is impossible in any event, the writer points out, because doctors could never agree on a set of guiding principles. But even if they could, he believes that lawful euthanasia would place too powerful a weapon in the hands of medical men: "There are inevitably some



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NEO-CULTOL suppresses putrefactive bacteria and distressing flatulence. Moist, lubricated, comfortably passed evacuations are the rule—without rush, griping, strain, or leakage.

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The name
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MEDICAL ECONOMICS • MARCH 1954

NEWS

who could hardly be trusted with [it]."

While stoutly maintaining his opposition to legal euthanasia, however, the doctor frankly refuted a couple of generally accepted arguments against it:

1. It's useless, he insists, to keep a "hopeless" patient alive in the hope that a new cure for his ailment will be discovered. "When a patient's vital organs have been all but destroyed . . . no new cure or treatment could ever reconstruct them."

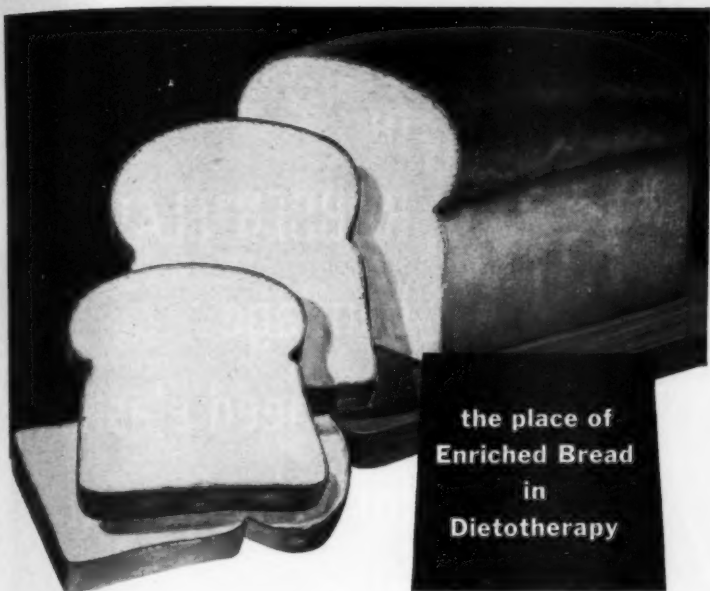
2. And the theory that a patient's life should be prolonged for the sake of medical science "has no validity . . . It is rare that anything useful can be learned from observing the terminal stages of a well-known disease."

The author admits that his stand is based on practical rather than moral grounds. But in the final analysis, he maintains, "whether or not [mercy killing] is morally defensible can only be answered in the mind and heart of the doctor who contemplates it."

Is Older Student Less Apt to Achieve M.D.?

The older a student when he enters medical school, the less likely he is to get his M.D. That's the conclusion of psychiatrists Don P. Morris and Carmen Miller, based on a study of six successive classes at Southwestern Medical School of the University of Texas.

Their chief findings: Close to 90 per cent of the 297 students who be-



the place of
Enriched Bread
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In the many instances encountered in everyday practice when dietary adjustment assumes a therapeutic role, the special diet gains in nutritional value when the bread included is enriched bread.

Enriched bread, today the bulk of commercial bread, contains important amounts of added B vitamins, iron, and in most instances nonfat milk solids. Because it supplies significant quantities of essential nutrients that are metabolically required regardless of the condition under treatment, enriched bread deserves a place in virtually all special purpose diets, including those for weight reduction. In the latter, two or three slices of enriched bread, the quantity usually allowed, contribute needed calories as well as essential nutrients in noteworthy amounts.

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pound, provides at least 1.1 mg. of thiamine, 0.7 mg. of riboflavin, 10 mg. of niacin, and 8 mg. of iron. By and large, enriched bread as marketed also supplies about 400 mg. of calcium and 39 Gm. of protein. Since the protein consists of flour and milk proteins, it is biologically valuable for growth as well as tissue maintenance. Thus enriched bread can make a significant contribution to the satisfaction of daily requirements in dietotherapy.

Bread rounds out virtually every diet. Because it is readily digested and contains only an insignificant amount of indigestible residue, enriched bread is rarely—if ever—contraindicated.



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came doctors were no more than 27 when they entered the school. But almost 30 per cent of the seventy-two students who failed to graduate were over 27 upon admission.

Why do the older students seem to have a harder time making the grade? According to Drs. Morris and Miller—writing in the *Journal of Medical Education*—such students may be less physically robust, may be under extra financial or social pressures, and may not be “really sure [they] want to study medicine.”

Opposes Free Clinics

Traditionally free clinics may one day give way to pay-what-you're-able clinics, at least in New York City. A proposal to make such a change has been advanced by Dr. Elaine P. Ralli, director of out-patient services for the city's Department of Hospitals. She backs up her plan by pointing to these problems currently facing the clinics:

1. Since just one of them handles 376,000 patients a year, it's obvious that the cost of the program is “staggering.” If this care is to continue, “some financial help must be forthcoming.”

2. Patients tend not to appreciate the care they get for nothing, and many make unnecessary visits to the clinics. In fact, in “countless cases ... patients are going to a physician and paying a fee, in addition to coming to the clinic” for free care.

3. Finally, it's “almost physically



ACCENT ON YOUTH: at 27, Roswell B. Perkins is Assistant Secretary of Health, Education, and Welfare.

impossible for physicians to continue to give their time [to the clinics] without remuneration.”

Young Lawyer Named to Top Welfare Post

It looks as though the Eisenhower Administration's key man on old-age affairs will be a very *young* man—27-year-old Roswell B. Perkins, a New York City attorney.

As a special assistant to the Secretary of Health, Education, and Welfare, he captained the task force that framed the Administration's proposals for extending Social Security to doctors and other professional men. And now he has been named Assist-

ant Secretary of the Department.

Perkins holds A.B. and law degrees from Harvard (where he also played football); he was an ensign in the Navy just after World War II; and he gained prominence in Republican circles by heading Youth for Eisenhower in the New York area during the 1952 campaign.

Public Told to Be Calm About Antibiotics

In an effort to shed "new light on the wonder drugs," Changing Times, The Kiplinger Magazine, offers some advice that many doctors will applaud. For instance:

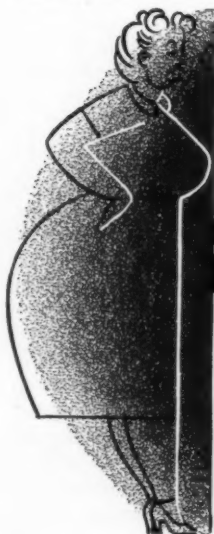
¶ "Always tell the doctor whether you have ever had the drug he pre-

scribes. By all means, tell him if you have had bad effects from the drug previously."

¶ "Don't pester the doctor with prescribing the drugs for small ailments." The magazine goes on to warn against indiscriminate use of antibiotic ointments, nosedrops, and lozenges.

¶ Patients are advised not to demand that the physician prescribe the latest antibiotic—nor to be afraid of it, if he proposes it. "The doctor will determine as far as is humanly possible whether or not you can safely take the drug."

¶ And finally, "Be absolutely sure to follow your doctor's orders; [and] if any unusual symptoms occur, call the doctor."



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with low-reserve thyroid. Mild thyroid deficiency "is a fairly common condition . . . characterized by weight gain, lassitude, brittle fingernails, coarse hair and . . . menstrual abnormality."¹ In this condition, accompanying thyroid medication may be of distinct help to the dietary regimen in reducing the patient.²

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1. Buxton, C. L., and Vann, F. H.: *New England J. Med.* 236: 836, 1947
2. Cuahney, A. R.: *Textbook of Pharmacology and Therapeutics*, ed. 10. Philadelphia, Lea & Febiger, 1943, pp. 436-437.



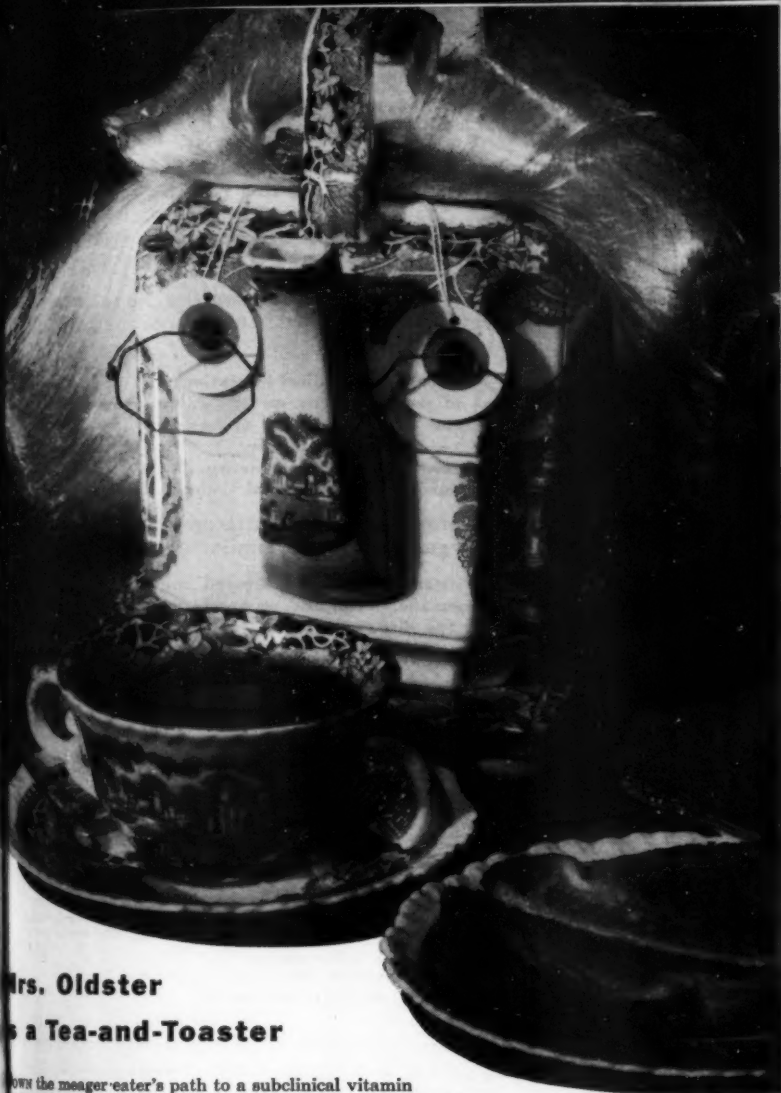
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Memo

FROM THE PUBLISHER

Circulation Policy

You've probably taken a look at the subscription letter on the first page of this issue.* You may even have torn off the accompanying postcard and mailed it by now (thus assuring that you'll continue to get **MEDICAL ECONOMICS** for the remaining months of 1954).

In doing so, you may have wondered just what our circulation policy is. So perhaps this is as good a time as any to tell you about it.

Private physicians under retirement age (131,000 of them at latest count) have always received **MEDICAL ECONOMICS** without charge. To keep their subscriptions in force, they're asked to sign and return periodic "request cards," like the one in this issue.

Young physicians starting out in practice get a free subscription without requesting it; for this constitutes their introduction to the magazine.

Other medical men—those who are not in private practice or who have reached retirement age—can get complimentary subscriptions,

*A relatively small number of copies do not carry the letter. Those are earmarked, in general, for advertisers, for paid subscribers, and for holders of special complimentary subscriptions.

too. About 5,000 residents, for example, come under this heading.

But we ask these doctors to take the initiative themselves: They must write in once a year, asking to remain on the list.

Finally, there are two classes of paid subscribers: medical students (who pay a special rate of \$1.50 a year); and dentists, hospital managers, medical administrators, prepay plan executives, and the like, who can get the magazine at the standard annual rate of \$5.

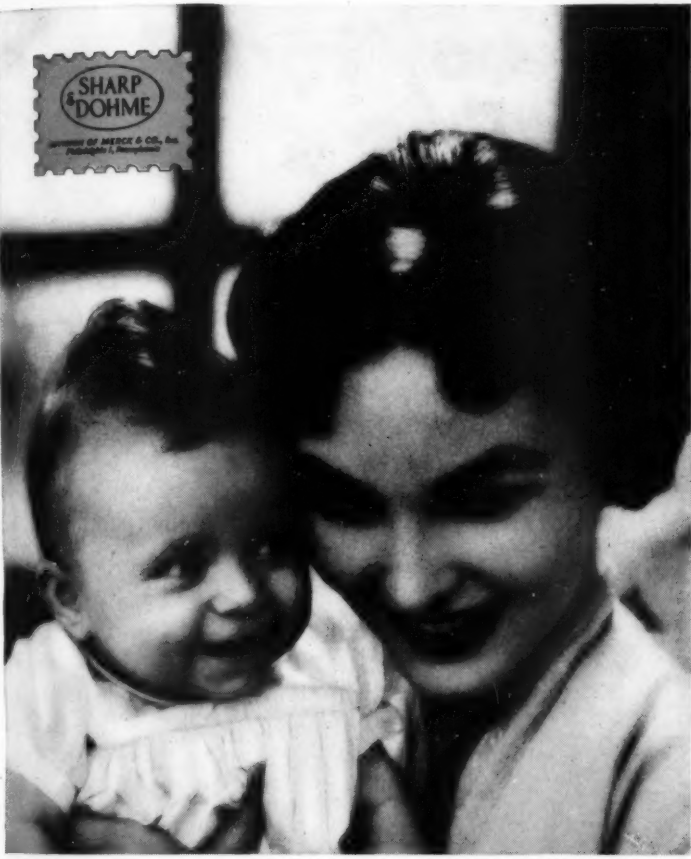
The policy of supplying request cards is comparatively new at **MEDICAL ECONOMICS**. During its first twenty-seven years, the magazine was sent to practicing physicians whether they asked for it or not.

Then, in 1950, we decided to switch to the present basis, in order to cut out any possible waste circulation. That fall, we mailed the first request cards to doctors—with gratifying results. Over 96 per cent of all eligible physicians asked to continue receiving the magazine.

Now, for the first time, we're dispatching the request cards inside the magazine itself, rather than by separate mail. We hope, by this means, to make the cards even more readily available for signing and returning.

Which, of course, brings me back to the main point:

Filling out a request card is the one sure way to keep **MEDICAL ECONOMICS** coming regularly to you each month. —LANSING CHAPMAN



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